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Associations among parenting, depressive symptoms, socialization of coping, and youth coping with family conflict in Latinx families

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Associations among parenting, depressive symptoms, socialization of coping, and youth coping with family conflict in Latinx families

by

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Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

August 2021

Acknowledgements

I would like to firstly thank the families who participated in this study for welcoming me into their homes and sharing their time, experiences, and wisdom. Their generosity, openness, and insight was truly humbling. I would also like to thank my advisor and mentor, Dr. Erin Rodríguez, who supported and assisted me throughout the process of writing this dissertation and in my graduate training more generally. I would also like to express my gratitude to the members of my dissertation committee, Drs. Bearman, Calzada, and Whittaker for their time and expertise, as well as the many faculty members at the University of Texas at Austin that I have had the privilege of learning from in my academic and clinical training. Thank you to my own *familia* – biological, academic, and chosen – for helping me cope with the many stressors of a graduate degree. I would also like to acknowledge the indigenous peoples whose land I inhabited over the course of completing this dissertation and my graduate training in Austin, Texas, including the Tonkawa, Comanche, and Lipan Apaches. I hope the results of this research will be used to help promote the well-being and resilience of marginalized communities, including those which I and other researchers have benefited from.

Abstract

Associations among parenting, depressive symptoms, socialization of coping, and youth coping with family conflict in Latinx families

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The University of Texas at Austin, 2021

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Latinx[1] youth in the U.S. have among the highest rates of functionally impairing depressive symptoms compared to other racial and ethnic groups (e.g., Ivey-Stephenson, et al., 2020; Potochnick & Perreira, 2010), and there is great need for research on risk and protective factors in this population. Identifying sources of resilience in Latinx families in the face of adversity are vital to developing culturally relevant interventions to support the well-being of Latinx families (e.g., Crean, 2004). Certain parenting behaviors (e.g., Hill, Bush, & Roosa, 2003), parent coping suggestions (e.g., Abaied & Rudolph, 2010), and youth coping skills (e.g., Compas et al., 2017) have been found to protect against the depressive symptoms in the general

[1] Note: In this paper, the term "Latinx" will be used to refer to the broad population in the U.S. that traces their ancestry to Latin America (including Mexico, Central America, South America, and the Caribbean). This term was chosen in order to be more inclusive of individuals who do not identify as having Spanish ancestry (as is implied in the term "Hispanic") and who do not identify as fitting into the male-female gender binary (as is implied in the terms "Latino" or "Latina").

population. However, the relationship between parenting dimensions and youth depressive symptoms has been less consistent in Latinx samples compared to non-Latinx samples (Luis et al., 2008; Varela et al., 2009, 2013), and limited research has examined the relationship between coping and youth depressive symptoms in Latinx youth. In addition, family conflict (e.g., Céspedes & Huey, 2008; Costello et al., 2003; Deardorff, Gonzalez, & Sandler, 2003; Seidman et al., 1999) and youth coping with family conflict (Wadsworth & Compas, 2002) have each been found to be strong predictors of youth depressive symptoms across racial and ethnic groups, but limited research has examined how parents' suggestions for how to cope with family conflict can protect against youth depressive symptoms.

The present study utilizes longitudinal and multi-informant data to examine the relationships among parental acceptance, youth coping with family conflict, parent coping suggestions, and youth depressive symptoms in Latinx families while controlling for the effects of parent depressive symptoms, baseline youth depressive symptoms, harsh parenting, and child gender. A sample of early adolescent Latinx youth and their parents who were primarily of Mexican descent and living in poverty completed measures at three time points over the course of a year. Path analysis was the primary statistical approach used. The results of the study indicate that primary control coping might be especially adaptive for Latinx youth in the context of family conflict, and might also be more easily taught to children through explicit instruction than other types of coping. Parent-report of primary control youth coping with family conflict and primary and secondary control coping suggestions negatively predicted youth depressive symptoms six months later. In addition, primary control coping suggestions were positively correlated with primary control youth coping and negatively correlated with disengagement youth coping. The results also indicate that parental acceptance is associated with the coping

suggestions parents give, as well as how youth cope with family conflict in Latinx families. Specifically, parental acceptance was found to be positively correlated with both primary and secondary control youth coping and every type of parent coping suggestion, and was negatively correlated with disengagement youth coping. Lastly, parent-report of primary control coping suggestions mediated the relationship between parental acceptance and primary control youth coping. The findings from this study are relevant to understanding factors that can protect against the development of depressive symptoms in this population, and could help inform culturally relevant, family-focused preventative interventions for Latinx youth at risk for depression.[2]

[2] This document – especially the literature review and methods sections – was influenced by this author's master's thesis: Moats, G.E. (2018). *The associations among parenting, socialization of coping, youth coping and youth depression in low-SES Latinx families*. [Master's thesis, University of Texas at Austin]. University of Texas Libraries. In addition to writing both manuscripts, this author assisted with collecting and analyzing the data that is referenced in both papers.

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Chapter 1: Literature Review

Overview

Studies[3] consistently find that Latinx youth have among the highest rates of functionally impairing depressive symptoms across racial and ethnic groups in the U.S. (e.g., CDC, 2020; Potochnick & Perreira, 2010). Mexican American youth, specifically, have been found to have higher depressive symptoms compared to other ethnic groups (Hill, Bush, & Roosa, 2003). Mexican Americans also represent the largest Latinx population in the U.S., with over 60% of Latinos being of Mexican descent (U.S. Census Bureau, 2019). Latinx youth face a high number of stressors that have been found to be positively associated with depressive symptoms and suicidality, including family conflict (Céspedes & Huey, 2008; Costello et al., 2003; Deardorff, Gonzalez, & Sandler, 2003). However, not all Latinx youth have these negative outcomes, so what protects against depressive symptoms in this population?

High parental acceptance (e.g., Hill, Bush, & Roosa, 2003; García, Manongdo, & Ozechowski, 2014), high youth engagement coping, and low youth disengagement coping (e.g., Compas et al., 2001) have each been found to protect against youth depressive symptoms in the general population and in Latinx samples. Researchers have additionally found that parents socialize their children to use certain coping strategies in part by making suggestions to their

[3] This document – especially the literature review and methods sections – was influenced by this author's master's thesis: Moats, G.E. (2018). *The associations among parenting, socialization of coping, youth coping and youth depression in low-SES Latinx families*. [Master's thesis, University of Texas at Austin]. University of Texas Libraries. In addition to writing both manuscripts, this author assisted with collecting and analyzing the data that is referenced in both papers.

children of how to cope with stressors, and these suggestions can also be predictive of depressive symptoms, depending on the nature of the stressor (e.g., Abaied & Rudolph, 2010). Coping in response to family conflict appears to be an especially important predictor of youth depressive symptoms (Conger & Donnellan, 2007; Deardorff, Gonzalez, & Sandler, 2003). However, to the knowledge of this author, no conceptual model has previously been proposed or tested that includes all mentioned variables in a single model. Given the unique combination of stressors faced by this population (Potochnick & Perreira, 2010), the cultural value of *familismo* (Germán, Gonzalez, & Dumka, 2009), and existing findings that the effects of parenting on youth depressive symptoms may be different in Latinx compared to non-Latinx families (Luis et al., 2008; Varela et al., 2009, 2013), it is possible that the relationships between these variables may also be different in this population, and therefore deserve investigation. In addition, the majority of existing studies examining the relationship between parenting and youth coping in Latinx families have been cross-sectional, relied on single informant data, utilized measures with poor psychometric properties, and not controlled for other factors that may influence the development of youth depressive symptoms, such as parental depressive symptoms. The present study aims to address this public health need and related gap in the literature by utilizing a longitudinal design and multi-informant data to examine pathways between parenting, coping suggestions, youth coping, and youth depressive symptoms in the context of family conflict within a sample of Latinx families.

Youth Depression and Depressive Symptoms

Major Depressive Disorder (MDD) is one of the most prevalent mental health conditions among Latinx youth and it appears to be rising (CDC, 2020; Potochnick & Perreira, 2010; McCance-Katz, 2018). MDD is the most common form of depression and is defined by the

Diagnostic and Statistical Manual, Fifth Edition (DSM-5) as a period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image (APA, 2013). Depressed mood in youth can often present as irritability rather than sadness (Thapar et al., 2012), and lack of understanding about developmental differences in presentation contribute to the under-identification of depression in youth (Avenevoli & Steinberg, 2001). Estimates of the prevalence of clinical depression in the general population of youth in the U.S. range between 5% (Costello, Erkanli, & Angold, 2006) and 12% (Center for Behavioral Health Statistics and Quality, 2016). Lifetime incidence of clinical depression increases dramatically from 1% of the population under age 12 to 17%–25% of the population by the end of adolescence (Kessler et al., 2005). The prevalence of MDD has been found to rise dramatically between the ages of 13 to 18 years (Kessler et al., 2005). The National Comorbidity Study of over 10,000 adolescents estimated that the lifetime prevalence of MDD in youth between 13 and 18 years of age is around 11% (Avenevoli et al., 2015). Episodes of MDD in adolescents receiving treatment have been found to average seven to nine months (Sullivan, Neale, & Kendler, 2000). Longitudinal studies of community and clinical samples have found that 50–70% of adolescents whose symptoms remit develop a subsequent episode within five years (Dunn & Goodyer, 2006; Lewinsohn, et al., 2000). This suggests that for many youth, once clinical depression emerges, it can affect them for many years. In addition, adolescent onset of depression is associated with a more chronic, severe, and disabling course of illness than adult-onset depression (Zisook, et al., 2007).

The National Academy of Medicine and the National Research Council and Institute of Medicine (2009) reported that subclinical symptoms of depression in youth often present two

years before meeting diagnostic criteria for MDD, which provides an important window of opportunity for preventative intervention. A large proportion of youth experience sub-clinical levels of depressive symptoms (Kessler & Walters, 1998; Angold, Costello, Farmer, Burns, & Erkanli, 1999). These youth report as much or nearly as much functional impairment as those with MDD, and seek treatment at the same or higher rates (González-Tejera et al., 2005). In addition, though a categorical definition of depression is required for clinical diagnosis (i.e., number and duration of symptoms above a cut-off), latent structure analysis has found that youth depressive symptoms are continuously, not categorically, distributed (Hankin, Fraley, Lahey, & Waldman, 2005). In addition, a continuum approach to assessing depressive symptoms is often used in research as it enables examination of both clinical severity and correlates with severity, and also yields greater statistical power (Avenevoli et al., 2008).

Etiological theories of depression include genetic, cognitive, biochemical, evolutionary, environmental, and developmental factors (e.g., Rudolph, Flynn, & Abaied, 2008). The vulnerability-stress theory of depression posits that depression emerges due to the interaction between a cognitive predisposition and the presence of stress (Ingram, Miranda, & Segal, 1998). In this conceptualization, both risk and stress exist along a continuum of severity, such that when there is a high vulnerability, a low level of stress is needed to trigger depressive symptoms or episodes. The genetic heritability of lifetime MDD has been estimated to be at least 30% to 40% (Sullivan, Neale, & Kendler, 2000). Research on adverse childhood experiences (ACEs) has found that exposure to early trauma (e.g., experiencing child abuse, witnessing violence, loss of a parent) accounts for roughly 50% of the risk for lifetime MDD in adults (Chapman et al., 2004). Number of adverse childhood experiences has also been positively associated with depressive symptoms in youth in early adolescence (Balistreri & Alvira-Hammond, 2016; Flouris & Kallis,

2011). Stress related to peers, finances, and family have each been found to be related to the depressive symptoms in youth across racial and ethnic groups (Deardorff, Gonzalez, & Sandler, 2003). In addition, the increased rates of depressive symptoms observed between childhood and adulthood are thought to be caused by hormonal, neurobiological, social, and cognitive changes during this developmental period (Thapar et al., 2012). Normal changes in the structure of the brain that occur during adolescence may contribute to stress sensitization relevant to depression. It has been theorized that adolescents might be especially vulnerable to stress during periods of very rapid brain development, and predispositions to depression might be more likely to be triggered during periods of synaptic pruning (Leussis & Andersen, 2008).

Depressive Symptoms in Latinx Youth

Researchers have found that Latinx youth in the U.S. have among the highest rates of clinical depression and depressive symptoms compared to other ethnic groups (Potochnick & Perreira, 2010). In 2018, the national survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that 15.1% of Latinx adolescents had experienced an episode of MDD in the past year (McCance-Katz, 2018). The prevalence of depressive symptoms has been especially well-documented among Mexican American youth (Choi et al., 2006; Hill, Bush, & Roosa, 2003). There has been evidence of higher rates of depressive symptoms among Afro-Latinx adolescents (Ramos et al., 2003) and Puerto Rican adults (Wassertheil-Sommer et al., 2014) compared to other Latinx groups. A national study of youth mental health found that Latinx youth ages 11 to 15 years old had higher rates of depressive symptoms (22%) than non-Latinx White (18%), Asian (17%), and Black (15%) youth (Saluja et al., 2004). The CDC's 2019 national survey of youth risk behaviors found that 40% of Latinx high school students reported feeling so sad or hopeless almost every day for two weeks or more in a row within the previous

year that they stopped doing some usual activities. This was higher than for non-Latinx White (36.0%) and Black (31.5%) youth (CDC, 2020).

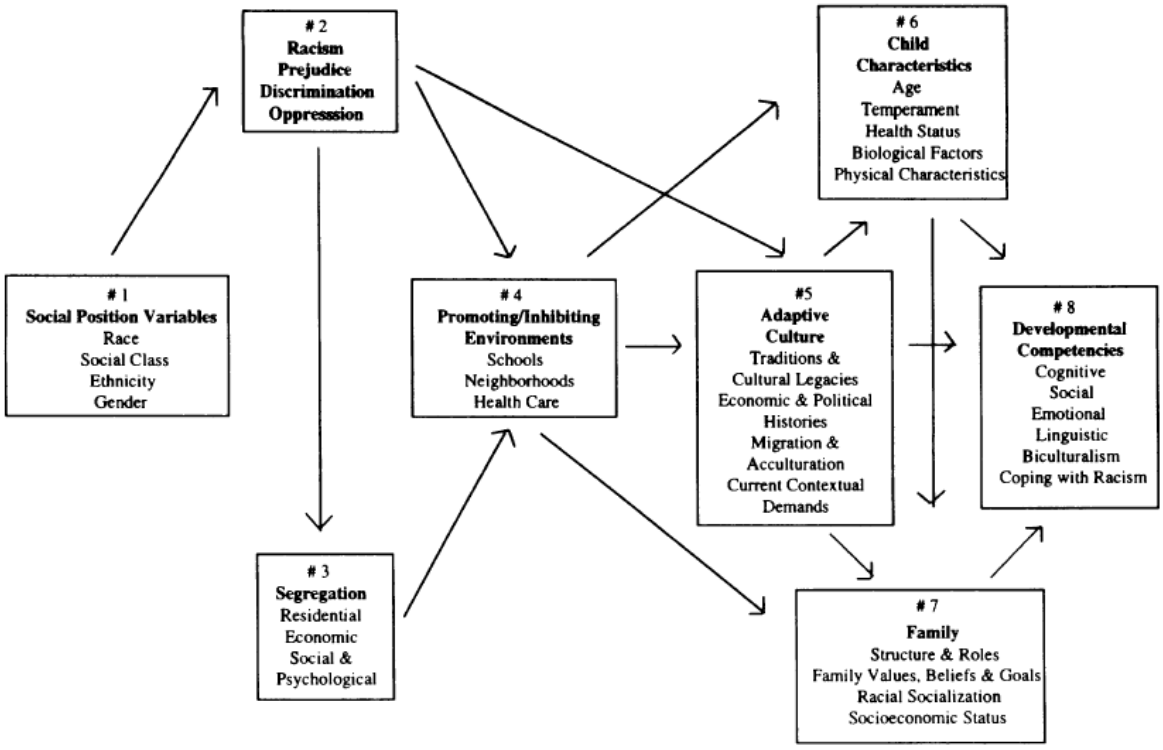
Depressive symptoms are the strongest predictor of suicidal ideation and attempts (Cash & Bridge, 2009), both of which have also been found to be elevated among Latinx youth. Adolescent onset of depression is associated with more suicide attempts than adult depression (Zisook, et al., 2007), and most suicide attempts by Latinx individuals occur prior to age 18 (Fortuna et al., 2007). Depressive symptoms have been found to be among the strongest predictors of suicidality in community samples of Latinx adolescents (O'Donnell et al., 2004). Between 2009 and 2015, Latinx high schoolers were also consistently more likely to attempt suicide than non-Latinx White, Black, and Asian high school students, second only to American Indian/Alaska Native and multiracial youth (CDC, 2016). Rates of attempts in non-Latinx Black youth appear to have surpassed Latinx youth in recent years. In 2019, 8.9% of Latinx high school students had attempted suicide in the previous year, compared to 11.8% of non-Latinx Black youth and 7.9% of non-Latinx White youth (Ivey-Stephenson, et al., 2020). Notably, suicide risk increases across generations for Latinx individuals, with risk greatest for those born in the U.S. (Silva & Van Orden, 2018). In line with general suicide trends, Latina girls are roughly twice as likely to plan or attempt suicide than Latino males (Ivey-Stephenson, et al., 2020). Surveys have indicated above-average rates of suicidality in Latinx subgroups, including Colombian, Cuban, Dominican, Ecuadorian, Mexican, Nicaraguan, and Puerto Rican Latinas (e.g., Baca-Garcia et al., 2010; Fortuna et al., 2007). These saddening trends point to the urgency for identifying risk and protective factors associated with depressive symptoms in Latinx youth.

Integrative Model for Minority Youth

Latinx adolescents experience multiple stressors that have been found to contribute to the development of depressive symptoms, including poverty (Goodman et al., 2003; Najman et al., 2010), discrimination (Balis & Postolache, 2008), stress related to immigration and documentation status (Potochnick & Perreira, 2010), acculturative stress (Hovey & King, 1996), and acculturation gaps with parents (Huq, Stein, & Gonzalez, 2016). Exposure to chronic environmental stressors has been consistently shown be a major risk factor for internalizing psychopathology in childhood and adolescence (Grant, McMahon, Duffy, Taylor, & Compas, 2011). García Coll et al. (1996) proposed an integrative conceptual model to make sense of how the multiple stressors faced by minority youth in the United States impact child development. The model explains how social position variables (e.g., social class, race, ethnicity, gender) and discrimination influence contextual, cultural, historical, family, and individual variables to eventually predict the wide range of developmental outcomes observed among children of color. These outcomes include cognitive, social, emotional, linguistic, and cultural competencies.

Figure 1

The Integrative Model for the Study of Developmental Competencies in Minority Children by García Coll et al. (1996)



Note. Reprinted from "An integrative model for the study of developmental competencies in minority children," by García Coll, C., Lamberty, G., Jenkins, R., McAdoo, H., Crnic, K., Wasik, B., & Vazquez García, H. (1996). *Child Development*, 67, 1891–1914.

There are several components of the model that are particularly relevant to the present study. The authors describe how historical experiences of discrimination, segregation, migration, and acculturative stress lead to the development of situationally adaptive coping mechanisms in communities of color. In particular, they explain how increased reliance on family members and expanded social networks in minority communities may have cultural origins, but may also in part be maintained by environmental demands. When communities can't rely on discriminatory institutions and systems for support, they are forced find alternative survival strategies to meet their needs. In addition, one developmental outcome included in the model is how minoritized

youth cope with racism. The authors explain that racial and ethnic minority children have the additional developmental competencies of learning about their racial or ethnic group identity and learning to cope with discrimination. In addition to providing a conceptualization of the pathways between stressors, this model represents an estimate of the number of stressors potentially faced by minoritized youth. This is important context to consider, as research indicates that number of risk factors, not a specific risk factor, best predicts youth outcomes (Sameroff & Fiese, 1989).

García Coll et al.'s (1996) model provides a helpful backdrop for understanding the broader context in which depression emerges for Latinx youth living in poverty. However, additional theoretical models and research are helpful for understanding how specific factors contribute to depressive symptoms in this population.

Poverty & Youth Outcomes

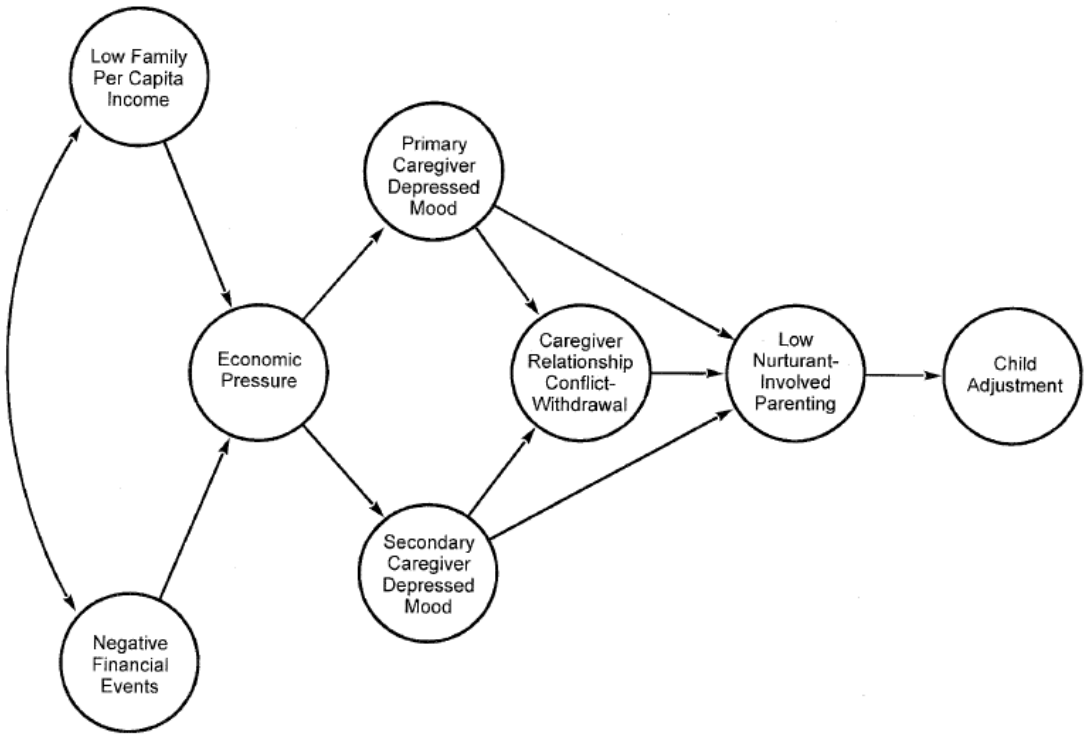
One of the factors most proximal to youth outcomes in García Coll et al.'s (1996) model is socio-economic status (SES). Specific components of SES are present throughout the model, such as social class, economic/residential segregation, and access to education. One aspect of SES, poverty, has been found to be a significant risk factor for depressive symptoms across racial/ethnic groups in the U.S. (Goodman et al., 2003; Najman et al., 2010). Understanding the impact of poverty on youth mental health is important when studying Latinx youth as census data has estimated roughly 23% of Latinx individuals in the U.S. live at or below the poverty line, which is over twice that of non-Latinx Whites at 10.1% (United States Census Bureau, 2015).

Conger et al. (2000; 2002) proposed the Family Stress Model, which describes how low family income indirectly predicts youth outcomes by contributing to the following stressors in

the family: depressed mood in caregivers, tension between caregivers, and disrupted parenting. Conger et al. (2000) explain that parents who are under financial stress tend to have more conflict with their partners and may have less emotional or physical energy available for their children. Due to stress, these parents may have fewer nurturing interactions and more hostile interactions with their children and use either overly harsh or inconsistent discipline.

Figure 2

The Family Stress Model by Conger et al. (2002)



Note. Reprinted from "Economic pressure in African American families: a replication and extension of the family stress model," by Conger, R. D., Wallace, L. E., Sun, Y., Simons, R. L., McLoyd, V. C., & Brody, G. H. (2002). *Developmental psychology*, *38*(2), 179.

Extensive cross-sectional and longitudinal research supports the theory that economic pressure impacts youth adjustment indirectly through parents' depressed mood, caregiver conflict, and disrupted parenting (e.g., Conger et al., 2000). Research also suggests that adolescents may be particularly impacted by caregivers' financial stress compared to younger children (Conger et al., 2000). This is likely due to adolescents' increased awareness and understanding of their surroundings and others' emotional states, as well as the increased sense of competency and responsibility that occurs at this age. The impact of parent depressive symptoms and parenting on youth depressive symptoms will be described later in this document.

Caregiver conflict is not a focus of the present study, but a related construct, family conflict, will be addressed.

Family Conflict & Youth Depressive Symptoms

Conger et al.'s (2000) conceptualization of family stress includes several important family-level variables related to youth depressive symptoms, but does not include bidirectional conflict between children and family members. Studies have shown that interpersonal (i.e., relationship) stress better predicts youth depressive symptoms than non-interpersonal stress (e.g., academic, financial, etc.; Rudolph et al., 2009; Rudolph, Flynn & Abaied, 2008). When compared to other stressors, family conflict – which includes arguing with family members, arguing between other family members, wanting to spend more time with family members, and not feeling understood by family members – has consistently been found to be among the strongest predictors of depressive symptoms in adolescents, including in ethnically diverse and low-income samples (e.g., Céspedes & Huey, 2008; Deardorff, Gonzalez, & Sandler, 2003; Hovey & King, 1996; Seidman et al., 1999). Frequent or severe instances of parental or sibling conflict have been found to be related to increased risk for psychopathology among youth (Conger & Donnellan, 2007). Family conflict has also been found to partially mediate the relationship between economic stress and adolescent depressive symptoms in low-income families (Wadsworth & Compas, 2002). In addition, level of family conflict has been associated with how parents respond to and reinforce children's emotion regulation (Nelson, et al., 2009).

Family conflict may be an especially strong predictor of depressive symptoms in Latinx youth. A supportive family environment (Hovey & King, 1996) and a strong value of *familismo* (Peña et al., 2011) have each been consistently identified as protective against depressive symptoms in Latinx youth. Family support has been found to protect against depressive

symptoms in Mexican American youth, specifically (Crean, 2004; Pagan Rivera, 2015). However, there is evidence that family conflict is even more predictive of youth well-being than family support (Barrera, 1981). Crean (2004) found that social conflict, which included conflict with family members, was predictive of internalizing symptoms in a majority Mexican American sample of youth in middle school. In addition, family conflict has been more strongly associated with depressive symptoms for Latinx adolescents compared to non-Latinx adolescents (Mechanic & Hansell, 1989). Given the importance of family in Latinx culture, it may be especially important to examine youth depressive symptoms and coping in the context of family conflict (White, Roosa, Weaver, & Nair, 2009).

Coping

A long-standing theory in contemporary conceptualizations of depression is the presence of low perceived control. Youth with depression have been found to have a low sense of agency, personal competency, and control over the events in their lives (e.g., Weisz, Francis, & Bearman, 2010). Coping skills are ways that individuals respond to stress in an attempt to exert control over events or their own responses to them. The relationship between coping and depressive symptoms will be described in more detail in a later section.

A construct that is often confused with coping is emotion regulation. Like coping, emotion regulation skills have been found to be highly predictive of depressive symptoms (Compas et al., 2017). The most commonly cited definitions of emotion regulation focus on the processes of monitoring, evaluating, and modifying emotional responses (Compas et al., 2017; Grolnick, Caruso, & Levitt, 2019). Emotion regulation involves cognitive components like problem solving and cognitive reappraisal (Gross & Thompson, 2007) that result in the individual's ability to modulate their emotional state, as well as behavioral expressions of their

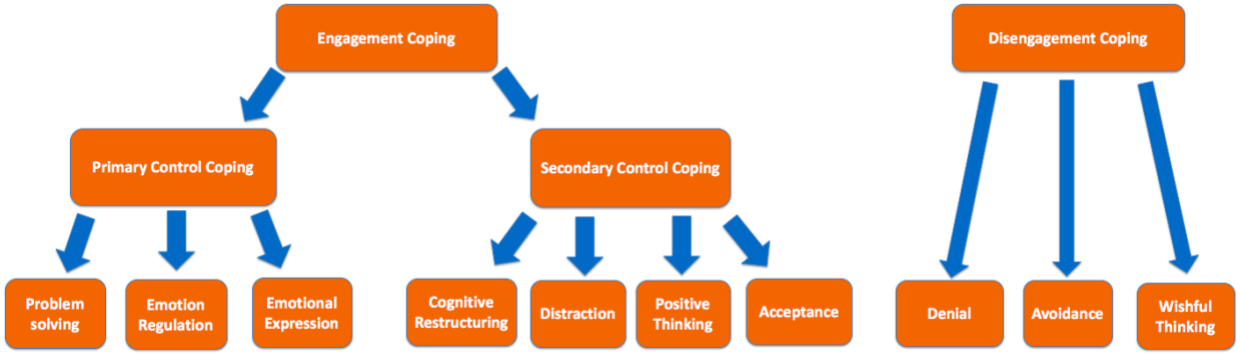
emotions (Eisenberg et al., 2010). Like coping, emotion regulation is both a voluntary and regulatory process (Compas et al., 2017), and children need modeling, guidance, and opportunities to practice in order to develop this skill (Grolnick, Caruso, & Levitt, 2019). The two constructs differ primarily in that emotion regulation can occur in response to any emotion, and coping can only occur in response to a stressor. Therefore, a given emotion regulation strategy (e.g., problem solving, emotional expression, avoidance, etc.) could be considered coping if there is a precipitating stressful event (Compas et al., 2017). In addition, emotion regulation does not encompass the additional cognitive, behavioral, or physiological processes present in coping. As Compas et al. (2017) explain, coping is simultaneously both a narrower and a broader construct than emotion regulation. Research has found that parents support children's emotion regulation by modeling positive affect, accepting children's emotions, helping them identify their emotions, discussing the causes for the emotions, providing distraction, or soothing (Power et al, 2004 for review).

Many models of coping have been proposed and tested, but the Five Factor Model of Response to Stress by Compas et al. (2001), also known as the control-based model of coping, has among the strongest evidence of empirical validity and is widely used. The model differentiates between two broad categories of coping strategies: disengagement coping and engagement coping. Disengagement coping involves attempts to separate and disengage from the stressor (i.e., avoidance, denial, or wishful thinking). In contrast, engagement coping involves attempts to actively control the situation, through either "primary control" or "secondary control". Primary control refers to efforts to either change the stressor or one's emotional response to the stressor (i.e., problem solving, emotional expression or emotional modulation). Secondary control refers to efforts to adapt to or accommodate a stressor (i.e., acceptance,

distraction, cognitive restructuring, or positive thinking). A review of over 100 models of coping found that models of coping that describe the function of coping (e.g., problem- vs. emotion-focused coping) are not supported by confirmatory factor analysis, perhaps because coping strategies generally serve multiple functions (Skinner, Edge, Altman, & Sherwood, 2003). Instead, models that measure higher order action types, like Compas et al.'s (2001) control-based model of coping, take into account that coping methods are multifunctional and have strong empirical support.

Figure 3

Reproduction of the Control-Based Model of Coping by Compas et al. (2001)



Existing cross-cultural research on coping has found that people across cultures tend to cope in similar ways (Crean, 2004). In a study of Latinx youth, Umaña-Taylor et al. (2008) found that an aspect of ethnic-racial identity was positively associated with "proactive coping" with discrimination, which is similar to engagement coping. Research based on the Compas et al. (2001) model of coping has demonstrated it has cross-cultural validity. A measure of coping based on this model (the Response to Stress Questionnaire) has demonstrated similar factor structure and good reliability and validity with ethnically diverse samples, including non-Latinx White adolescents (Compas et al., 2006; Connor-Smith et al., 2000), indigenous American

(Navajo) adolescents (Wadsworth et al., 2004), and adolescents in Spain (Connor-Smith & Calvete, 2004), Bosnia (Benson et al., 2011), and China (Xiao et al., 2010). This measure also been used in a handful of studies with Latinx populations (e.g., Santiago et al., 2017), and there is evidence that the two-factor structure (engagement and disengagement coping) fits Mexican American samples similarly to non-Latinx White samples (Valiente, Lemery-Chalfant, & Swanson, 2009).

Coping and Depressive Symptoms

Existing research has found that in general, engagement coping strategies are associated with fewer internalizing symptoms, and disengagement coping strategies are associated with more internalizing symptoms in youth (e.g., Compas et al., 2001, 2012, 2017; Wadsworth & Compas, 2002). The first existing quantitative meta-analysis of youth coping and psychopathology, conducted by Compas et al. (2017), included over 200 cross-sectional and longitudinal studies and over 80,000 participants. This meta-analysis provides some of the strongest evidence of the relationship between youth coping and depressive symptoms. Among the cross-sectional studies examined, both primary control coping and secondary control coping were found to be significantly negatively associated with both internalizing and externalizing symptomatology in youth, even when controlling for publication bias (unadjusted and adjusted effect sizes ranged from small to medium, r=-.14 to -.30). The protective effects of primary control coping against youth depressive symptoms have been especially well documented in the extant literature (Morling & Evered 2006; Rothbaum et al., 1982). However, there is also evidence that secondary control coping may predict psychopathology more strongly than primary control coping. A study of over 2,000 youth in early adolescence (11 to 14 years old) found that secondary control coping predicted 41% of the variance in youth depressive symptoms, while

primary control coping predicted 9% of the variance (Weisz, Francis, & Bearman, 2010). In contrast, disengagement coping has been found to be positively associated with internalizing and externalizing symptomatology. In the meta-analysis by Compas et al. (2017), disengagement coping significantly positively predicted internalizing symptoms (r=.18). This was the only significant path the authors found among longitudinal studies. The authors suggest this finding could be partly due to the comparatively low number of longitudinal studies available for inclusion in the study and highlight a need for longitudinal studies in the field.

Recent research suggests that coping is not a stable trait – individuals do not employ the same coping strategies with all stressors (Compas et al., 2001; Lazarus, 1993). In addition, the effectiveness of a coping strategy is determined by its match with the stressor (Abaied & Rudolph, 2010; Compas et al., 2001; Lazarus, 1993). Primary control coping appears to be most adaptive when stressors are within an individual's control, and secondary control is helpful when stressors are out of an individual's control (Compas et al., 2001). There is some evidence that when stressors are out of the individual's control, disengagement coping strategies may also be adaptive. Studies have found that in circumstances such as economic disadvantage, neighborhood violence, chronic illness, and child abuse, disengagement coping can reduce the likelihood of internalizing problems, including depressive symptoms (Chaffin, Wherry, & Dykman, 1997; Dempsey, Overstreet, & Moely, 2000; Gonzalez, Tein, Sandler, & Friedman, 2001; O'Brien, Bahadur, Gee, & Balto, 1997; O'Brien, Margolin, & John, 1995).

How children cope with daily stressors has been found to be more predictive of mental health than how the child copes with rare, major events (Compas, 1987; Wagner, Compas, & Howell, 1988). Preliminary studies with the general population suggest that youth coping with family conflict may be especially protective against youth depressive symptoms. Specifically,

research has found that low-SES youth who use either primary or secondary control strategies to cope with family conflict exhibit lower rates of depressive symptoms than youth who use disengagement coping strategies (Wadsworth & Compas, 2002). Paradoxically, low-SES youth faced with high levels of family conflict have been found to be less likely to use primary and secondary control coping (Wadsworth & Compas, 2002) and more likely to use disengagement coping (Power, 2004) compared to youth with low levels of family conflict. A study with an ethnically diverse sample of low-SES youth that included Latinx adolescents found that secondary control coping with family conflict protected against internalizing symptoms one year later (Santiago & Wadsworth, 2009). Primary control coping with family conflict was also protective, but only for girls in the sample, and disengagement coping was positively associated with later depressive symptoms for both girls and boys.

Coping & Depressive Symptoms in Latinx Youth

Cross-cultural research on coping has found that relationships between coping and depressive symptoms are similar across racial and ethnic groups (Compas et al., 2017; Galaif et al., 2003). Prior studies have found that engagement coping is negatively associated with psychopathology in Latinx individuals – both directly and indirectly. A study with Mexican American adolescents found that those who reported using more direct problem solving, positive thinking, acceptance, and humor reported more positive mood, and those using more distancing reported more negative affect (Aldridge & Roesch, 2008). Crean's (2004) study of stress and coping in Latinx middle school students found that "approach" coping with acute life stressors (defined as attempts to problem solve and positively reframe a problem, similar to engagement coping) was negatively associated with psychopathology in a predominantly Mexican American sample of youth and mediated the relationship between social stress and internalizing symptoms.

"Active coping" (defined as one's attempt to master his or her environment, also similar to engagement coping) has been associated with a decreased risk for depressive symptoms in Mexican American youth (Gonzáles, Tein, Sandler, & Friedman, 2001) and also found to mediate the relationship between acculturative stress and depressive symptoms (Torres & Rollock, 2007). "Shift-and-persist", a group of secondary control coping strategies focused on cognitive reappraisal, positive future orientation, and meaning in life, has been found to buffer against the effects of both financial stress and discriminatory stress on depressive symptoms in Latinx youth living in poverty (Christophe et al., 2019). However, this type of secondary control coping with discrimination was not found to protect against depressive symptoms in low-SES Latinx youth who had high ethnic-racial identity, suggesting that secondary control coping with discrimination might provide protection against depression in the absence of a strong ethnic-racial identity.

The limited studies that have used the RSQ measure of coping with Latinx youth has found that engagement coping with financial stress (as measured by a brief version of the RSQ) can buffer against low mood in samples of Mexican American middle schoolers (Santiago et al., 2017). In addition, in a study with sample that was primarily comprised of 7- to 12-year-old Mexican American youth, researchers found that engagement coping with peer conflict as measured by the RSQ mediated the relationship between parenting and adjustment problems, which included depressive symptoms (Valiente, Lemery-Chalfant, & Swanson, 2009). There is also evidence that secondary control youth coping with parent cancer is protective against depressive symptoms only when *familismo* is high (Marin, 2017).

In contrast, disengagement coping has been found to be detrimental to Latinx youth. A study with Mexican American college students found that "avoidant coping" (defined as

behavioral and emotional attempts to avoid a problem, similar to disengagement coping) predicted high levels of depressive symptoms in this sample (Crockett et al., 2007). In one of the few prior longitudinal studies of coping and depressive symptoms with a high-risk sample Latinx adolescents, Galaif et al. (2003) measured adolescent depressive symptoms, perceived stress, social support coping, and "anger coping" (defined as responding to stress in an aggressive or vengeful manner) at two time points 12 months apart. They found initial depressive symptoms (using the Center for Epidemiological Studies Depression Scale) predicted increased stress, and initial social support coping predicted decreased stress and anger coping. In addition, anger coping predicted increased depressive symptoms, stress, and decreased social support coping. Disengagement coping with academic and peer stress (as measured by a brief version of the RSQ) has been associated with worsening daily mood in samples of Mexican American middle schoolers (Santiago et al., 2017). Disengagement coping with peer conflict has been found to be positively associated with adjustment problems, which included depressive symptoms (Valiente, Lemery-Chalfant, & Swanson, 2009).

There is preliminary evidence that coping with family conflict, specifically, might be especially related to depressive symptoms for Latinx youth. Santiago and colleagues (2017) found that over 50% of youth in their majority Mexican American sample reported "family trouble/change" and 38% reported "family conflict" as regular stressors. These were among both the most commonly reported and most stressful stressors for the sample. In their study of low-income Mexican American families, Dumka, Roosa, and Jackson (1997) found that child-report (but not parent-report) of family conflict was positively associated with youth depressive symptoms. The study by Santiago and Wadsworth (2011) with a sample of low-income Latinx youth and parents (predominantly Mexican American) found that family coping with poverty-

related stress that was similar to secondary control coping (called "family reframing") negatively predicted internalizing symptoms. In contrast, coping strategies similar to disengagement coping (called "passive appraisal") positively predicted internalizing symptoms. Coping strategies similar to primary control coping with poverty-related stress were not found to significantly predict internalizing symptoms (Santiago & Wadsworth, 2011). It is possible that since family conflict is more within a child's control than poverty, primary control coping skills with family conflict might be adaptive for Latinx youth living in poverty.

Many studies of the nature of coping and its relationship to depressive symptoms for youth have methodological limitations. First, a majority of studies did not include Latinx samples. Second, the majority of studies in the coping literature to date have been cross-sectional (Compas et al., 2017). Cross-sectional studies provide information about correlations between variables, but not about the directions of the relationships. Third, most studies on youth coping utilize single informants. Researchers generally recommend that multiple informants be used when assessing psychological constructs, especially in children, but this is not often done in the coping literature (Compas et al., 2001, 2017). Reliance on a single informant provides one perspective, whereas examining multiple informants allows for examination of associations across different contexts. Fourth, there is limited research on how coping with family conflict, specifically, impacts depressive symptoms in Latinx youth. Lastly, the majority of existing studies of the relationship between coping and depressive symptoms in Latinx samples have used poorly validated models and measures of coping. Given these methodological limitations, there is a great need for rigorous research on the relationship between coping and depressive symptoms for Latinx youth utilizing evidence-based measures of coping, longitudinal designs, and multiple informants.

Parenting Constructs

Parenting has long been theorized and demonstrated to contribute to children's psychological outcomes (e.g., Leidy, Guerra, & Toro, 2012). Early research in the field of parenting was guided by the seminal theory of "parenting styles" developed by Baumrind (1991) and Maccoby and Martin (1983). An individual caregiver's parenting style is determined by how their behavior is categorized on multiple "parenting dimensions". Parenting dimensions are groups of discreet parenting practices (e.g., asking a child to clean up after herself) that have the same objective (e.g., obedience, independence, etc.; Darling & Steinberg, 1993). Parenting practices have been defined as "what parents do", and parenting styles are "how they do it" (Lansford, 2019).

The parenting styles developed by Baumrind (1991) and Maccoby and Martin (1983) include two dimensions: "parental responsiveness" and "demandingness". Parental responsiveness (also known as warmth or acceptance) is defined by parent behaviors such as sharing, expression of affection, and providing emotional support (e.g., "your parent spoke to you in a warm and friendly voice"; Nair, White, Knight, & Roosa, 2009). Parental demandingness refers to having high behavioral expectations, as well as the use of consequences or punishments for misbehavior (e.g., "when your mother made a rule for you, she made sure it was followed"; Nair, White, Knight, & Roosa, 2009). These two dimensions produce four parenting styles: "authoritative parenting", which is high in both demandingness and responsiveness; "authoritarian parenting", which is high in demandingness and low in responsiveness; "permissive parenting", which is low in demandingness and high in responsiveness; and "uninvolved parenting" which is low in both demandingness and responsiveness (e.g., Baumrind, 1991; Weiss & Schwarz, 1996). Another term for authoritative

parenting often used, especially in the intervention literature, is "positive parenting" (defined as including warmth, limit-setting, appropriate scaffolding, and consistency). In contrast, "negative parenting" is similar to authoritarian parenting, and is defined as harsh, inconsistent, controlling, and over-reactive (Taraban, 2018).

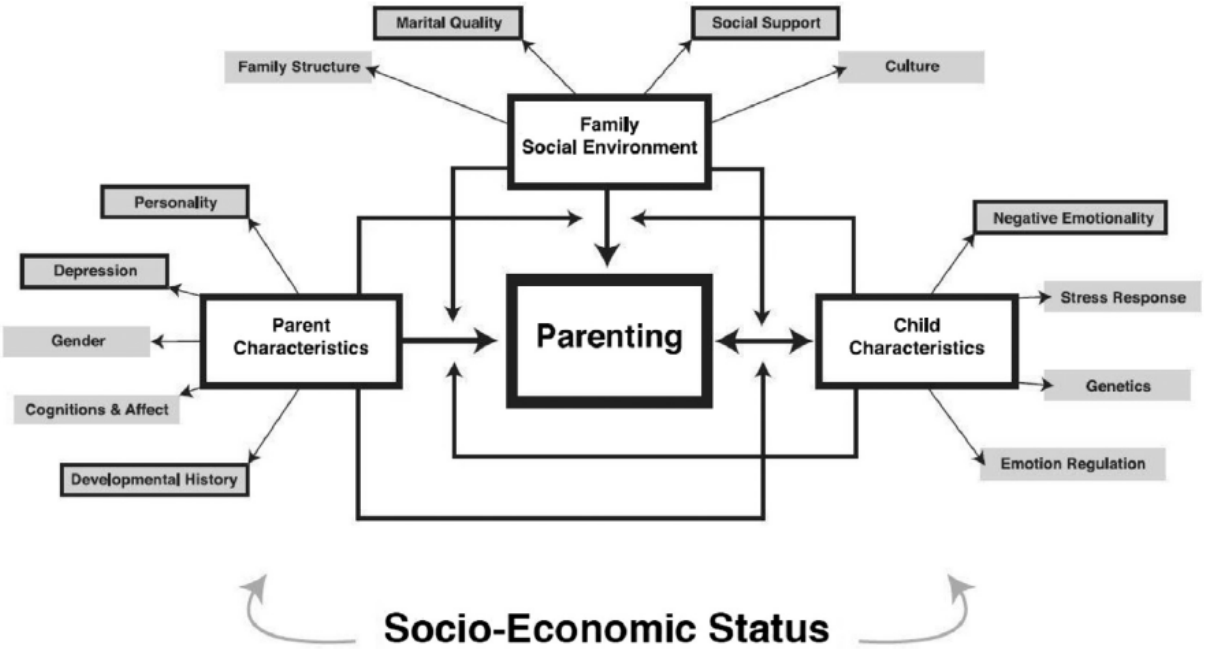
In recent years, researchers seeking to understand the relationship between parenting and youth outcomes have increasingly used parenting dimensions as the unit of analysis (e.g., White, Roosa, Weaver & Nair, 2009). Schaefer (1965) proposed a three-dimensional model of parenting that resulted in one of the longest standing and most widely used measures of parenting dimensions called the Children's Report of Parenting Behavior Inventory (CRPBI; Schaefer; 1965). It was developed to capture children's perceptions of their parents' child-rearing behaviors, since children's perceptions of parenting was seen as more relevant to their adjustment than observed parent behaviors (Margolies & Weintraub, 1977; Schludermann & Schludermann, 1970). The model is comprised of three bimodal dimensions: parental acceptance, consistent discipline, and hostile control. Parental acceptance (also known as responsiveness or warmth) has already been defined. Consistent discipline is similar to the previously described dimension of demandingness, but specifically refers to consistent behavioral expectations and use of reasonable punishments when appropriate (Nair, White, Knight, & Roosa, 2009). Hostile control includes yelling, insulting, physical punishment, and psychological manipulation of the child (e.g., "your father got so mad at you that he called you names"). Hostile control is also similar to another commonly referred to parenting dimension in the literature, called "parental rejection" (McLeod, Weisz, & Wood, 2007). Factor analyses consistently show good model fit using these three factors from the CRPBI (e.g., Barrera et al., 2002; Schaefer; 1965; Schludermann & Schludermann, 1970).

Predictors of Parenting

There are many factors that have been found to be predictors of parenting. Belsky's (1984) seminal theoretical model of determinants of parenting includes both parent-specific and child-specific variables (e.g., personality, development, relationships; Belsky, 1984). Though initially developed to conceptualize parenting in early childhood, this model importantly includes research on fathers, and also highlights the bidirectional relationship between parenting and child characteristics. Belsky's model was recently updated by Taraban (2018) to include additional, specific variables within factors based on the current state of the scientific literature. Within the child-specific variables, negative emotionality has been especially widely-studied, and has been associated with higher levels of harsh parenting and lower levels of authoritative or positive parenting (for a review, see Crockenberg & Leerkes, 2003). Negative emotionality is a temperamental tendency to react to stressors with high irritability, sadness, or fear (Paulussen-Hoogeboom et al., 2008), has been associated with both child internalizing problems (Rothbart & Bates, 2006; Waldman, Singh, & Lahey, 2006) and parenting (Rothbart, 2011). While children who are sociable, flexible, and easy to sooth are likely to elicit warm/responsive parenting, those with negative emotionality may be more difficult to manage (Crockenberg & Leerkes, 2003), which is more likely to evoke harsh parenting or withdrawal of attention (Paulussen-Hoogeboom et al., 2007).

Figure 4

Updated Process of Parenting Model by Taraban (2018)



Note. Reprinted from "Parenting in context: Revisiting Belsky's classic process of parenting model in early childhood" by Taraban, L., & Shaw, D. S. (2018). *Developmental Review*, *48*, 55–81.

Latinx Parenting

Parenting Styles in Latinx Families

The literature on the nature of Latinx parenting is complex, and suggests that no single type of parenting is characteristic for Latinx parents (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012; Hill, Bush, & Roosa, 2003; Varela et al., 2004). Some studies have found that Latinx parents use more authoritarian practices than non-Latinx parents (e.g., Knight, Virdin, & Roosa, 1994; Varela et al., 2004). Other studies have found that though Latinx parents use more authoritarian practices compared to other racial/ethnic groups, similar to other groups, they still use more authoritative than authoritarian practices overall (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012; Varela et al., 2004). In contrast, Hill, Bush, and Roosa (2003)

found no significant group differences in the prevalence of authoritative parenting between Mexican national, Mexican-born immigrants, U.S.-born Mexican Americans, and non-Latinx White parents in a low-income neighborhood in the U.S. Given these conflicting findings related to parenting styles, it can be helpful to examine specific parenting dimensions within Latinx populations.

Parental Warmth in Latinx Families

Cross-cultural research suggests that parental warmth/acceptance is a universal dimension of parenting (Halgunseth, 2019). Parental warmth/acceptance can be expressed in many ways, and these behaviors are culturally situated (Halgunseth & Ispa, 2012). Mexican American parents report expressing warmth through physical affection also, verbal praise for desired behavior, and making time to *platicar* (have informal conversations) with their children (Halgunseth & Ispa, 2012). There is evidence that *familismo* (familism) affects parental warmth in Latinx families. *Familismo* has been defined as attitudes and behaviors that emphasize the centrality of the family unit by highly valuing familial obligations, emotional closeness and support, and behavior expectations (Germán, Gonzales, & Dumka, 2008). In their study of Dominican and Mexican immigrant mothers, Serrano-Villar, Huang, and Calzada (2017) found that mothers who perceived greater support from their family were likely to demonstrate more warmth to their children.

Parental Harshness in Latinx Families

Parent hostility has been a focus of the literature on Latinx parenting. Some studies have found that Latinx parents use more hostile parenting practices than non-Latinx parents (e.g., Knight, Virdin, & Roosa, 1994; Varela et al., 2004). For example, Hill, Bush, and Roosa (2003) found that low-income Mexican American parents used hostile control and inconsistent

discipline more than low-income non-Latinx White parents. However, multiple studies with diverse samples of Latinx families of varying generational statuses have found that the Hostile Control factor of the Children's Report of Parental Behavior Inventory (CRPBI; Schaefer, 1965) measure may not hold for Latinx samples (Knight, Tein, Shell, & Roosa, 1992; Varela et al., 2009). Given these findings, one group of researchers modified the Hostile Control factor and scale of the CRPBI and called it "Harsh Parenting" in order to be more appropriate for Latinx families (Nair, White, Knight, & Roosa, 2009). This will be further described in subsequent sections. Financial stress has been consistently positively associated with harsh parenting in Latinx families (White et al., 2015).

Parental Control in Latinx Families

Latinx parenting is often described in the literature as high in parental control. Parents' attempts to exert control over children include physical guidance, directing and modeling, protection and monitoring, rule-setting and decision-making, physical and verbal punishment, and psychological and emotional control (Halgunseth, Ispa & Rudy, 2006). Studies have found that Latinx parents use more controlling practices than non-Latinx parents (Hill, Bush, & Roosa, 2003; Knight, Virdin, & Roosa, 1994; Varela et al., 2004). Some have hypothesized that parental control in Latinx families may be a function of specific cultural goals and values, such as interdependence, *familismo* (familism) and *respeto* (respect; Halgunseth, Ispa & Rudy, 2006; Kim, Chen, Hou, Zeiders, & Calzada, 2018). Qualitative studies have found that Mexican American and Puerto Rican mothers value obedience and respect more than the dominant American values of independence, autonomy, and assertiveness (Zayas & Rojas-Flores, 2003). For example, Fischer, Harvey, and Driscoll (2009) found that Latina mothers highly valued control over children's behavior and believed they valued it more than mothers in the dominant

U.S. culture. In addition, high parental control might be an adaptive response to parenting within the discriminatory contexts experienced by many minoritized and immigrant families (e.g., Bradley, 2019; Halgunseth, 2019). Parents living in dangerous environments might attempt to ensure their children's safety through high parental control.

Associations Across Parenting Dimensions in Latinx Families

Some dimensions of parenting have been found to be associated with one another for Latinx parents. Researchers who analyzed interactions between Mexican immigrant parents and their children (ages four- to nine-years-old) found that Baumrind's (1966) four parenting styles did not accurately capture the data. Instead, they found that the majority (61%) of parents were high in warmth, high on demandingness, and low on autonomy granting, and called this style "protective parenting" (Domenech Rodríguez, Donovick, & Crowley, 2009). Hill, Bush, and Roosa (2003) found that unlike non-Latinx parents or English-speaking Latinx parents, Spanish-speaking Latinx parents tended to use high levels of both hostile control and acceptance.

Similarly, White et al. (2013) found a portion of Mexican American parents who displayed simultaneously high warmth, harshness, and control. The authors theorized that these dimensions of parenting may be highly correlated because the use of harshness or hostile control along with high levels of warmth or acceptance may mitigate the negative effects typically associated with harsh parenting, and may be especially adaptive in certain contexts of high stress (e.g., high-crime neighborhoods). This aligns with the cross-cultural literature on spanking, that has found that for non-Latinx White American, Black American, and Latinx families, when parents provide high emotional support, spanking does not increase the risk of behavioral problems (McLoyd & Smith, 2002). Parental warmth has been found to buffer against the impact of harsh parenting on Latinx youth's adjustment. In German and colleagues' (2013) study of

low-income Mexican American adolescents, they found that at higher levels of maternal warmth, harsh discipline was not significantly correlated with externalizing problems. These results underscore the importance of examining parenting dimensions rather than styles when attempting to understand the nature of parenting in minoritized communities.

Parental Directiveness & Intrusiveness in Latinx Families

Two specific types of parental control that are relevant to this study and have been noted in Latinx families are intrusiveness and directiveness. These dimensions have been thought to differ only in the accompanying emotion from the parent (Ispa et al., 2013). Intrusive parenting refers to parents' verbal directives that interrupt a child's activity and is accompanied by a negative affect in the parent. Directive parenting similarly refers to parents' use of verbal directives but without a negative affect (Halgunseth, 2019). The majority of research on directiveness and intrusiveness has been conducted with young children, but Mexican American parents have been found to be more directive than non-Latinx White parents (Ispa et al., 2013). Some have argued that prior conceptualizations of Latinx parenting as "intrusive" have a pejorative connotation and might not have considered the cultural relevance of these practices (Halgunseth, 2019).

Parental Communication in Latinx Families

Focus group research conducted with Latinx parents of children in elementary and middle school indicates that Latinx parents see communication as a pillar of good parenting. Qualitative studies with Mexican American (Livas-Dlott et al., 2010), Dominican, and Puerto Rican parents (Guilamo-Ramos et al., 2007) have found that Latinx parents believe communication is an important inductive teaching strategy to improve children's behavior. Parent-child communication that includes explaining parents' decisions and the consequences of misbehavior

has been associated with improved compliance in Latinx children (Livas-Dlott et al., 2010). A qualitative study of the "protective parenting" style by Durand (2011) found that Latinx parents reported frequently explaining to children how to be safe, behave with peers, and find help when needed. Parents in the study also emphasized that children should inform parents of risks and problems in their lives so that they could best protect them.

There is a dearth of quantitative research on parent-adolescent communication in Latinx families (Halgunseth, 2019). Within the existing studies, Mexican American and Central American parents of elementary- through high school-age children have reported engaging in more communication with their children than both non-Latinx White parents and parents in Mexico (Varela et al., 2009).

Moderating Variables in Latinx Parenting

There are many conflicting findings in the literature on the nature of Latinx parenting, and these may in part be due to differences in samples (Ayón, Williams, Marsiglia, Ayers, & Kiehne, 2015). Recognition of the heterogeneity in this population has led contemporary researchers to examine differences between subpopulations within this large and diverse group. Level of acculturation is one important distinguishing factor in the population. Several studies have examined the relationship between parenting and parent level of acculturation. For example, less acculturated Latinx mothers in the U.S. have been found to use more authoritarian practices compared to more acculturated Latinx mothers (e.g., Parke et al., 2004). In contrast, mothers with a higher English competence and acculturation level have been found to use more authoritative practices, including embracing values like independence for their children (González-Ramos, Zayas, & Cohen, 1998).

Many studies have used preferred language as a proxy for level of acculturation (e.g., Hill, Bush, & Roosa, 2003), and there is evidence that language competence is associated with other domains of acculturative status (Calzada et al., 2012). One study found that less U.S.-acculturated (Spanish-speaking) Mexican American mothers reported using more inconsistent discipline and hostile control compared to more acculturated (English-speaking) Mexican American mothers (Hill, Bush, & Roosa, 2003).

Generation status can also be an important indicator of level of acculturation. Interestingly, studies comparing Mexican American parents to parents in Mexico have found Mexican American parents use more authoritarian strategies than Mexican national parents. In their cross-cultural study, Varela et al. (2004) found that Mexican immigrant (first generation) and Mexican American (second generation and up) mothers and fathers reported greater use of authoritarian practices than parents in Mexico and non-Latinx White parents in the U.S. In contrast, parents in Mexico and non-Latinx White parents in the U.S. had similar rates of authoritarian parenting style. These results suggest that parents change their parenting in response to contextual stressors (e.g., acculturative stress, discrimination, low-income neighborhoods), and parenting may be better predicted by ecological context than by ethnicity (Varela et al., 2004). Authoritarian parenting may not be characteristic of Mexican or Latinx culture, but rather of Latinx families adapting to life in the U.S.

There may also be differences in Latinx parents depending on country of origin. Much of the research on parenting in Latinx families has been conducted with Mexican American families, and is thought to be at least partially generalizable to other Latinx groups (De Von Figueroa-Moseley, Ramey, Keltner, & Lanzi, 2006). However, important differences across country of origin have emerged. Initial findings suggests that Mexican immigrant mothers may

use more authoritarian practices than Dominican immigrant mothers (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012), and Puerto Rican parents may use higher warmth and consistency in their parenting than Mexican American and Salvadorian parents (De Von Figueroa-Moseley, Ramey, Keltner, & Lanzi, 2006). Given these findings, it is important that researchers consider how country of origin may impact findings about parenting in Latinx families.

Parenting and Youth Depressive Symptoms

The impact of parenting on youth psychopathology – and youth depressive symptoms specifically – has been documented in both observational studies and randomized controlled trials of parenting interventions (e.g., Compas et al., 2010). Much of the research on the effects of parenting on children's mental health has been guided by the parenting styles developed by Baumrind (1991) and Maccoby and Martin (1983). This body of literature is expansive. In general, findings suggest that authoritative parenting is associated with healthy psychosocial functioning in youth, and other parenting styles (authoritarian, permissive, and uninvolved) are associated with poor psychosocial functioning, including depressive symptoms (e.g., Baumrind, 1991; Weiss & Schwarz, 1996). The relationship between parenting styles and depressive symptoms is generally believed to be similar across racial and ethnic groups (Darling, 1999). Just like in non-Latinx families, studies have found that authoritarian parenting predicts higher levels of child internalizing problems among multiple Latinx populations (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012; Parke et al., 2004). In contrast, parenting that is authoritative predicts lower levels of internalizing problems in Latinx youth (Dumka et al., 1997; Leidy, Guerra & Toro, 2012).

Recent research has moved away from the use of parenting styles as the unit of measurement, and instead examined the effects of parenting dimensions separately. Findings

from cross-cultural and international research suggest that parental warmth/acceptance is protective for youth mental health. Rohner and Britner (2002) compiled results from over 50 studies with thousands of participants from 25 nations and language groups across the world, and found that parental acceptance is negatively associated with depressive symptoms in adolescents. Researchers have found that children in the general population with a high familial risk of depression have lower rates of depressive symptoms if their relationships with their parents are characterized by warmth, acceptance, low hostility, and low parental control (Brennan, Le Brocque, & Hammen, 2003; Pargas et al., 2005). In addition, parental acceptance has been found to partially mediate the relationship between parent and youth depressive symptoms (Garber et al., 2011).

In contrast, "parental rejection" (defined as excessive disapproval, criticism, and lack of interactions with the child) and "parental control" (defined as high regulation of children's behavior, encouraging dependence on parents, and instructions to the child for how to think and feel) have most often been found to be positively associated with youth depressive symptoms in the extant literature (McLeod, Weisz, & Wood, 2007). In a meta-analysis by McLeod, Weisz, and Wood (2007) of 45 studies and almost 10,000 5- to 18-year-olds, the researchers found that parenting dimensions accounted for 8% of the variance in child depression, which is considered to be a moderate effect size. The authors argue that though this effect might be smaller than the general public's perception of the impact of parenting on youth depressive symptoms, parenting might be an important catalyst for the development of youth depression that merits examination.

McLeod, Weisz, and Wood (2007) found that the parenting dimension of parental rejection was more predictive of child depressive symptoms (with a moderate effect size) than parental control (with a small effect size), and the subdimension of parent hostility explained the

greatest proportion of variance in child depression (11%). Parental rejection is thought to contribute to youth depressive symptoms by undermining children's sense of self-worth and creating a sense of helplessness, which are thought to be common precursors for depression. Parental control is thought to contribute to depressive symptoms in youth by reducing their sense of mastery and creating a sense of helplessness. Hostile parenting is thought be a subdimension of parental rejection. McLeod, Weisz, and Wood (2007) clarify that in comparison to other parenting dimensions, the absence of parental warmth and the presence of hostile parenting might be most strongly linked to the development of low self-esteem that often leads to youth depression.

McLeod, Weisz, and Wood (2007) also found that how parenting and child depression were conceptualized and assessed in the studies included in their meta-analysis moderated the association between parenting and childhood depression. They urged that use of evidence-based measures, multi-informant data, and longitudinal studies are crucial to understanding the relationship between parenting and youth depressive symptoms. Notably, only one of the studies included in their meta-analysis included a majority Latinx sample, and the majority of studies were with non-Latinx White samples.

Parenting and Youth Depressive Symptoms in Latinx Families

There is evidence that relationships between parenting dimensions and youth depressive symptoms are similar for Latinx families. In their study of cultural differences in parenting, Hill, Bush, and Roosa (2003) found that the relationships between parenting dimensions of hostile control, acceptance, and inconsistent discipline with youth depressive symptoms were similar for low-income English-speaking Mexican American, Spanish-speaking Mexican American, and non-Latinx White American parents. Multiple studies have found that warm parenting is

associated with fewer depressive symptoms in Latinx youth and Mexican American youth, specifically (Dumka et al., 1997; Florsheim, Tolan, & Gorman-Smith, 1996; Gil-Rivas, Greenberger, Chen, & López-Lena, 2003; Gonzales, Pitts, Hill, & Roosa, 2000; Roosa et al., 1993; Wadsworth et al., 2013). In addition, positive and supportive parenting (high in warmth, proactive teaching, inductive discipline, and positive involvement) has been found to buffer against the negative impact of environmental stressors in low-income non-Latinx White American, Black American, and Latinx families (e.g., Barrera et al., 2002; Masten et al., 1988; Pettit, Bates, & Dodge, 1997; Wadsworth et al., 2013). Mexican American fathers' warmth protects against adolescents' internalizing problems when families live in low-crime neighborhoods (White et al., 2015).

However, there are some inconsistencies in the cross-cultural literature regarding relationships between parenting and youth outcomes across racial and ethnic groups (Darling, 1999) and with Latinx youth, specifically. Researchers have found that authoritarian parenting (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012) and inconsistent discipline (Florsheim, Tolan, & Gorman-Smith, 1996; Gonzales, Pitts, Hill, & Roosa, 2000; Roosa, Tein, Groppenbacher, Michaels, & Dumka, 1993) are not consistently predictive of depressive symptoms in Latinx youth. In addition, researchers have found that parental warmth, responsiveness, and acceptance do not predict mental health outcomes in Latinx youth as strongly as in non-Latinx White youth (Luis et al., 2008; Varela et al., 2009, 2013). Harsh parenting has also not been as consistently associated with youth mental health outcomes in Latinx youth in the extant literature (Calzada et al., 2012).

Intrusive parenting might have unique relationships with child outcomes in Latinx families compared to White non-Latinx families. The majority of research on directiveness and

intrusiveness has been conducted with young children, but cross-cultural studies indicate associations between directiveness or intrusiveness and child outcomes might differ for Latinx compared to non-Latinx youth. Ispa and colleagues (2013) found that high parent directiveness was associated with high negativity from children towards parents in low-income Black, White, and Mexican American families. However, the association was weakest for Mexican American families. The authors theorize that Mexican American mothers might deliver directiveness in ways that does not provoke a negative a reaction from youth, or directiveness might convey caring and a desire for connection within Mexican American culture. Within this cultural context, youth might not perceive parents' intrusiveness as aversive. In addition, parent-adolescent communication has also been found to protect against depressive symptoms in adolescents living in Mexico (Halgunseth & Ispa, 2012).

Some argue the lack of consistent findings regarding the relationship between parenting and youth depression in Latinx families are due to researchers using theories and measures based on non-Latinx White families (Hill, Bush, & Roosa, 2003; Varela et al., 2013). Cross-cultural scholars have proposed that authoritative parenting should not be considered universally optimal and authoritarian universally maladaptive (e.g., Calzada & Eyberg, 2002; Hill, Bush, & Roosa, 2003; Domenech Rodríguez et al., 2009; Livas-Dlott et al., 2010). It is possible that the effects of parenting on youth mental health vary due to differences in parents' values and goals, specific parenting practices, and the cultural meaning of practices (Darling, 1999; Darling & Steinberg, 1993; Hill, Bush, & Roosa, 2003).

The cultural value of *familismo* may be relevant to understanding relationships between parenting dimensions and youth depressive symptoms in Latinx families. Endorsement of *familismo* values has been found to protect against depressive symptoms in Latinx youth (Peña et

al., 2011). On the one hand, it could be that the centrality of family in Latinx culture causes parenting to be an especially important predictor of healthy psychological functioning in Latinx youth (Leidy, Guerra, & Toro, 2012). Lending support to this hypothesis, some studies have found that parent support is more likely to protect against depressive symptoms than peer support in Latinx young adults (Crockett et al., 2007). In contrast, others have hypothesized that the inconsistent findings regarding the impact of parenting dimensions on youth mental health could in part be due to the support they receive from family members besides their parents (Varela et al., 2013). Emotional support from extended family members has consistently been linked to lower levels of depressive symptoms in Latinx youth and adults (Hovey & King, 1996; Vega et al., 1991; Schneider & Ward, 2003). Similar findings and hypotheses have been made regarding Asian American youth (DeBaryshe, Yuen, & Stern, 2001).

There is also evidence that socioeconomic status may be more important than ethnicity in determining the relationship between parenting and youth depressive symptoms (Hill, Bush, & Roosa, 2003). Low-income parents have been found to use more physical punishment, value obedience, place more restrictions, and show more disapproval than high-income families (Baldwin et al., 1990; Deater-Deckard & Dodge, 1997; Furstenberg et al., 1993; Pinderhughes et al., 2000). These practices have a different meaning within this context, since parents may choose these practices because they feel they must control their child's behavior to ensure their child's safety. Though these practices fall within authoritarian parenting, they have been found to predict better child mental health outcomes in low-income, urban communities (Baldwin et al., 1990; Deater-Deckard & Dodge, 1997; Furstenberg et al., 1993; Pinderhughes et al., 2000). SES might also moderate the relationship between parenting and youth depressive symptoms in minoritized populations due to the presence of additional stressors that contribute to youth

outcomes in these communities. McLeod, Weisz, and Wood's (2007) meta-analysis found the association between parenting and youth depressive symptom was stronger in higher income families, and theorize this could be because other stressors are more predictive of depressive symptoms for youth living in poverty.

Some of the seemingly conflicting findings in the field of Latinx parenting and its correlates may be due to methodological differences across studies. Studies have used a range of measures and operationalized constructs differently (Ayón, Williams, Marsiglia, Ayers, & Kiehne, 2015). It is also notable that many of the existing studies on the effects of parenting on Latinx youth have been primarily cross-sectional and rely exclusively on parent self-report data. Cross-sectional studies provide information about correlations between variables, but not about the directions of the relationships, limiting our ability to understand whether and which aspects of parenting contribute to the development of depressive symptoms in Latinx youth. Research in the field of parenting has suggested that relying exclusively on parent-report of parenting behavior does not capture the important component of how youth perceive their caregivers' parenting choices (Schwarz, Barton-Henry, & Pruzinsky, 1985).

In addition, significant associations between harsh parenting and youth outcomes have been found to differ across parent- and child-report data (Deardorff et al., 2013; Knight, Virdin, & Roosa, 1994). Research in the field of psychopathology has found that parent-report of children's internalizing symptoms are often lower than youth's self-reports (Achenbach, McConaughy, & Howell, 1987; Lau et al., 2004). This suggests there is a need for research on the relationship between parenting and youth depressive symptoms in Latinx families that utilizes longitudinal designs and multiple informants.

Given these conflicting findings, there is need for research that identifies parenting dimensions that are protective against depressive symptoms in Latinx populations and also enhances our understanding of the pathways by which parenting impacts youth outcomes. Researchers have urged that there is especially a need for studies that explore which parenting dimensions are protective against depressive symptoms in recent immigrant Latinx families (Leidy, Guerra, & Toro, 2012).

Parental Depressive Symptoms and Youth Depressive Symptoms

It is well documented that parental depression is highly predictive of youth depression, and there are several theorized pathways. By middle childhood, youth with depressed mothers have been found to have a significantly increased risk of both internalizing and externalizing problems compared to those without depressed mothers (Goodman et al., 2011). The impact of parental depressive symptoms on youth depressive symptoms has also been replicated in Latinx samples (Corona, Lefkowitz, & Sigman, 2005). In addition to findings of the strong genetic heritability of depression (Sullivan, Neale, & Kendler, 2000), research suggests that parenting partially mediates the relationship between parental depressive symptoms and youth depressive symptoms (e.g., Elgar et al., 2007; Taraban, 2018). Parent depressive symptoms have been positively associated with uninvolved parenting, harsh parenting, and inconsistent parenting, each with a moderate effect size (Goodman et al., 2011; England & Sims, 2009; Lunkenheimer, Lichtwarck-Aschoff, Hollenstein, Kemp, & Granic, 2016). Maternal depression has also been negatively associated with warm and positive parenting, regardless of child age, with a small effect size (England & Sims, 2009). These parenting behaviors can disrupt the attachment between parent and child, which can lead to maladaptive assumptions about the self and relationships that are associated with internalizing disorders (Martins & Gaffan, 2000).

Emergent research also suggests parental depression may be most likely to impact parenting when parents are experiencing other stressors, including poverty (Lovejoy et al., 2000) and discrimination (Wilson & Durbin, 2010). A meta-analysis found that the relationship between maternal depression and child psychopathology was stronger for studies that sampled from families living in poverty compared to studies with mixed- or high-income families (Goodman et al., 2011). In addition, White, Roosa, Weaver, and Nair (2009) found that parental depressive symptoms mediated the effect of financial stress on parental warmth and inconsistent discipline in Mexican American families.

Parent depressive symptoms might also impact youth depressive symptoms indirectly through youth coping. There is strong evidence in the extant literature for an association between parent depressive symptoms and youth secondary control coping (Dunbar et al., 2013; Fear et al. 2009; Jaser et al., 2005). Evidence is less consistent for relationships between parent depressive symptoms and primary control or disengagement youth coping (Fear et al. 2009; Jaser et al., 2005). However, there is some evidence that parent depressive symptoms are negatively associated with primary control coping and positively associated with disengagement youth coping (Jaser et al., 2011). The majority of the research on parenting among depressed caregivers has been conducted with mothers, but findings appear to be similar for depressed fathers (England & Sims, 2009).

Parenting and Youth Coping

There is also evidence that parenting directly affects youth coping. Parenting styles and specific parenting practices (e.g., showing warmth, fostering open communication) have both been found to predict youth's emotion regulation skills, which is a component of adaptive coping (Morris et al., 2007). Positive parenting (i.e., warm, responsive, and consistent) has been found

to be related to children's greater use of engagement coping and lower use of disengagement coping in the general population (Gaylord-Harden, 2008; Power, 2004). Conversely, negative parenting (which is harsh, intrusive, uninvolved and/or coercive) has been found to be associated with greater use of disengagement coping and lower use of engagement coping strategies (Eisenberg, Fabes, & Murphy, 1996). Previous researchers have theorized positive parenting encourages children to use engagement coping because children with warm/responsive parents feel safe enough to engage with stressors, able to use their parents as a source of coping, and in a positive mood that makes them open to engaging with stressors (Vélez, Wolchik, Tein, & Sandler, 2011). In addition, parents who are high in warmth, responsiveness, and supportiveness might encourage their offspring to engage with the stressors in their lives because they are by definition attentive to their children's emotions, communicate that it is acceptable to engage with emotions, have high expectations of their children's capacities, and facilitate learning (Watson et al., 2014). These theories are supported by findings that parent assistance with emotional processing is positively associated with youth engagement coping (Prinstein, La Greca, Vernberg, & Silverman, 1996). However, researchers have noted that additional research is needed to test these theorized pathways (Power, 2004; Vélez, Wolchik, Tein, & Sandler, 2011).

Most studies that have examined the relationship between parenting and child coping skills have been cross-sectional, relied on single-informant questionnaire measures, and have been conducted on largely non-Latinx White samples. Some researchers have argued that this limits conclusions about the validity and direction of the relationship between parenting styles and children's coping (Watson et al., 2014). In the first longitudinal, randomized controlled study to examine the relationship between parenting and youth coping, Wolchik et al. (2007) taught a sample of recently divorced mothers (that was majority non-Latinx White) strategies to

improve the parent-child relationship and increase consistent discipline (e.g., active listening, positive family activities, parent emotion regulation, effective discipline), and also taught their children adaptive coping skills (e.g., emotion labelling, relaxation, problem solving, cognitive reframing). The study found that improvements in the parent-child relationship (as measured by a composite of mother- and child-report on the CRPBI and a measure of parent-adolescent communication), but not consistent discipline, predicted increases in children's active coping with a recent problem (as measured by child self-report on the Coping Strategies Checklist–Revised; Ayers, Sandler, West, & Roosa, 1996) six years later (Vélez, Wolchik, Tein, & Sandler, 2011). Interestingly, neither improvements in the parent-child relationship nor consistent discipline predicted decreases in children's avoidant coping. The results echo previous findings that consistent discipline may not be strongly predictive of youth coping, and also that avoidant/disengagement coping may be better predicted by individual differences than parenting (Power, 2004). They also found a lag in treatment effects – improvements in the parent-child relationship were not correlated with improved coping skills six months after completing the intervention, but were significantly correlated with improved coping skills six years later (Vélez, Wolchik, Tein, & Sandler, 2011).

Building on this study, Watson et al. (2014) conducted perhaps the only other existing longitudinal, multi-informant intervention study of parenting and youth coping. Using a sample of mostly White, non-Latinx children of parents with a history Major Depressive Disorder (MDD), the researchers assessed the relationship between parenting and youth coping before and after an intervention and compared the results to a control group. The intervention provided parents with psychoeducation on depression in youth and skills for managing children's stress and taught secondary control coping skills to youth. Prior to administering the intervention, the

researchers found a positive association between observed warm/responsive parenting (as measured by the observational Iowa Family Interaction Rating Scale; Melby et al., 1998) and children's primary and secondary control coping (as measured by a composite of mother- and child-report on the RSQ-Parent Depression Version; Connor-Smith et al., 2000). They also found a negative association between warm/responsive parenting and children's disengagement coping. After implementing the intervention, they found that increased parental warmth/responsiveness was associated with an increase in children's use of secondary control coping skills. They found that intervention-driven improvements in parental warmth/responsiveness from baseline to six-month follow-up (immediately post-intervention) significantly accounted for increases in children's use of secondary control coping from baseline to the 18-month follow up. The magnitude of this effect was 0.30. Similar to the findings from Vélez, Wolchik, Tein, and Sandler (2011) the findings from Watson et al. (2014) suggest that changes in parenting can cause changes in child coping. Specifically, an increase in warm/responsive parenting predicts an increase in youth's secondary control coping. As predicted, the intervention had no effect on children's use of primary control coping or disengagement coping strategies, as it did not target these. The lack of effect on disengagement coping also echoed previous findings by Vélez, Wolchik, Tein, and Sandler (2011) and others that changes in parent-child relationship quality do not predict changes in disengagement coping.

Though the studies by Vélez, Wolchik, Tein, and Sandler (2011) and Watson et al. (2014) provide strong evidence of the relationship between parenting and youth coping, both studies were conducted with samples that were primarily non-Latinx and White, and neither group of researchers examined racial or ethnic differences in the results. The researchers called for additional research with populations at risk for depression, in naturalistic settings, and on the

effects of low parental warmth/responsiveness on youth coping. In addition, they noted that additional research is needed to better understand socialization processes in the development of children's coping. The relationship between parenting dimensions and youth coping in Latinx families is currently not well understood and is a significant gap in the literature.

Coping Socialization

Researchers have argued that family is the most powerful context in which children learn coping skills, and parents are "socializing agents" (Kliewer, Sandler, & Wolchik, 1994; Power, 2004). However, relatively little is known about exactly how parents teach their children how to cope (Power, 2004; Wolchik & Sandler, 1997). Researchers have identified four broad ways in which parents may impact their children's coping: modeling, reinforcement, direct instruction, and family environment factors (Fisak & Grills-Taquechel, 2007; Kliewer, Fearnow, & Miller, 1996; Kliewer et al., 2006; Power, 2004). Some have argued that simply observing what coping strategies parents utilize when faced by their own stressors, children learn and utilize the same coping strategies (Fisak & Grills-Taquechel, 2007), and there is some evidence to support this (Gunzenhauser, Fäsche, Friedlmeier, & von Suchodoletz, 2014; Kliewer et al., 2006). However, there is also evidence that the relationship between parent and youth coping is not a neat one-to-one correlation (Power, 2004). In a community sample of 9- to 12-year-olds, Kliewer, Fearnow, and Miller (1996) examined the relationships between youth coping factors and those of their mothers' and fathers'. They found that only fathers'- and boys'-reports of active coping were positively associated. In a sample of critically ill mothers and fathers and their children, Kotchick, Forehand, Wierson, Armistead, and Klein (1996) found that only mothers' avoidant coping was significantly correlated with boys' avoidant coping, but the association was negative.

Reinforcement has long been recognized in the psychological literature as an effective technique for teaching behaviors (i.e., operant conditioning; Skinner, 2014). Reinforcement of children's active coping through positive parental responses (e.g., praise, hug) has been found to increase children's rates of active coping, whereas negative parental responses to children's active coping (e.g., minimizing the child's concern or punishing the child for seeking help or expressing emotions related to the stressor) has been related to more frequent use of avoidant or disengagement coping (Eisenberg, Fabes, & Murphy, 1996; Fisak & Grills-Taquechel, 2007; Hudson, Comer, & Kendall, 2008). Research has shown that supportive responses (e.g., praise, hug) to youth's negative emotions (e.g., sadness) predict more emotional expression, and unsupportive responses (e.g., ignoring, criticism) predict less emotional expression in youth (Nelson et al., 2009).

Additional family- and parent-level factors (called "the family environment") are also thought to be related to youth coping (Kliewer et al., 2006). This literature includes the ways in which family variables and parenting predict youth coping, which have already been reviewed in this summary of the literature, as well as factors beyond the scope of this study (e.g., parent personality, maternal attachment, family communication style, family cohesion, family competence in daily life, and problem-solving skills; e.g., Kliewer et al., 2006; Monti, Rudolph, & Abaied, 2014; Vélez, Wolchik, Tein, & Sandler, 2011).

Coping Suggestions & Youth Coping

The final way in which parents have been found to impact their children's coping is through what has been called "information transfer" (Fisak & Grills-Taquechel, 2007), "direct instruction" (Kliewer, Sandler, & Wolchik, 1994), "coaching" (e.g., Miller, Kliewer, & Partch, 2010) or "coping suggestions" (Abaied & Rudolph, 2010). This has been defined as parents'

explicit suggestions of how they think their child should cope with a stressor. Research on the impact of coping suggestions on youth coping is fairly limited, but there have been some promising findings. Preliminary research suggests that coping suggestions may have a larger impact on youth coping strategies than parent modeling or reinforcement of coping. Kliewer et al. (2006) found that when faced with community violence, mothers' coping suggestions were more predictive of youth's coping than mothers' modeling, reinforcement, or the family environment (Kliewer et al., 2006). Kliewer, Fearnow, and Miller (1996) also found that for some coping strategies, when parents both used and suggested the same coping strategy to a high degree, their children were more likely to use that coping strategy.

Emerging evidence indicates that the level of stress moderates the relationship between parent coping suggestions and youth coping. In one of the seminal studies of coping suggestions and youth coping, Abaied and Rudolph (2011) examined relationships between parent coping suggestions and youth coping related to bullying in a primarily non-Latinx, socio-economically diverse sample of early adolescents. The researchers found that high levels of disengagement coping suggestions from parents predicted high involuntary disengagement with the stressor in children. In addition, high levels of engagement coping suggestions predicted low levels of involuntary disengagement. However, these effects were only significant when peer stress was high. The authors theorized that since the cognitive and emotional demands of managing stress increase with the level of stress, youth might be more likely to avoid engaging with high stress. Therefore, youth might especially benefit from encouragement to engage with stressors from parents when experiencing high stress.

Preliminary research has identified several variables that might influence the coping suggestions parents give. Early research found that parent coping suggestions were associated

with parents' own coping, the quality of the parent-child relationship, and the broadly defined "family environment" (Kliewer et al., 1996). Some have found that parents who are high in warmth/responsiveness are more likely to engage children in conversations about coping, and therefore are more likely to encourage engagement coping rather than disengagement coping (Watson et al., 2013). Parents' attitudes toward reappraisal and emotion expression and regulation have been found to increase parents' use of these strategies, as well as their children's use of those coping strategies (Meyer, Raikes, Virmani, Waters, & Thompson, 2014). Children might also be more likely to ask for and accept parents' coping suggestions if there is a warm family environment with open communication between parents and children (e.g., Power, 2004). Additional research is needed to better understand the relationship between parenting dimensions and parent coping suggestions.

Coping Suggestions & Youth Depressive Symptoms

In addition to being related to youth coping, parent coping suggestions have been found to directly predict youth depressive symptoms. Another study by Abaied and Rudolph (2010b) of non-Latinx youth found that in the context of interpersonal stress (e.g., conflict with family or peers), as stress increased, disengagement coping suggestions better predicted depressive symptoms in youth, and the association was positive. However, disengagement coping suggestions were only significantly positively associated with depressive symptoms when children received low (not moderate or high) levels of engagement coping suggestions. The authors explain that the harmful effects of disengagement coping suggestions seem to be exacerbated as interpersonal stress increases, and engagement coping suggestions can protect against this. In the context of non-interpersonal stress (e.g., academic challenges), when this stress was high, disengagement coping suggestions positively predicted depressive symptoms,

but when non-interpersonal stress was low, disengagement coping suggestions *negatively* predicted depressive symptoms. This could be because disengagement suggestions for low non-interpersonal stress protect against maladaptive rumination on minor problems.

Overall, this research lends support to the idea that parents' coping suggestions for an interpersonal stressor like family conflict might be key to predicting child depressive symptoms. In addition, the harmful effects of disengagement coping suggestions seem to be exacerbated as stress increases, but the presence of engagement coping suggestions can buffer against this.

Coping Suggestions & Parenting

Though minimal research has explored the relationship between coping suggestions and parenting, there is some preliminary evidence to support this association. Abaied and Rudolph (2010a) examined the relationship between maternal adult attachment and the coping suggestions given by mothers to their early adolescent children. The authors developed the Socialization of Coping (SOC) measure of coping suggestions, which is based on the Compas et al. (2001) model of coping. Results indicated that maternal insecure attachment predicted fewer engagement coping suggestions and more disengagement coping suggestions. The authors propose that secure adult attachment (feelings of comfort and safety with close relationships) enables parents to have the emotional reserves necessary to adaptively cope with their own stressors and to be available to support children's adaptive coping. The study included a measure of the parent-child relationship as a control, but did not find that it was significantly correlated with mother-report of either engagement or disengagement coping suggestions.

There is also evidence that maternal emotional awareness and depression are associated with coping suggestions. In a study of coping suggestions specific to bullying with 2nd grade children, researchers found that mother's emotional awareness was positively associated with

primary control coping suggestions. In addition, maternal depressive symptoms were associated with fewer secondary control coping suggestions and more disengagement coping suggestions (Monti, Abaied, & Rudolph, 2014).

These preliminary results indicate that the parenting and coping suggestions have theoretical intersections, and the relationship merits study. Given the documented relationships between parental acceptance and harsh parenting with youth coping (Eisenberg, Fabes, & Murphy, 1996; Gaylord-Harden, 2008; Power, 2004), these dimensions of parenting might also be associated with coping suggestions. In addition, it remains unclear how children's perception of coping suggestions are related to parenting.

Coping Socialization in Latinx Families

To the knowledge of this author, no prior study has examined this type of coping socialization in Latinx families. However, research on collaborative coping in Latinx families is relevant to understanding how Latinx parents might teach their children to cope. Some researchers have theorized that Latinx families engage in more collaborative coping with family members when managing stressors due to cultural values of collectivism and *familismo* (Santiago & Wadsworth, 2011). "Family coping" refers to "strategies and behaviors aimed at strengthening the family as a whole, maintaining emotional stability and well-being of family members, and using family and community resources to manage a situation or event, and making efforts to problem solve family hardships created by stress" (Santiago & Wadsworth, 2011, p. 332). Family coping approaches can include engagement and disengagement coping strategies. It is possible that due to specific cultural values, Latinx parents and youth engage in more conversations about coping than non-Latinx families. It is therefore especially important to

understand what kind of parental coping suggestions are most protective against depressive symptoms for this population.

Limitations in the Research

There are several limitations in the literature on coping suggestions. First, to the knowledge of this author, no prior studies have examined coping suggestions in Latinx families. Several aspects of parenting that have been identified in the literature as common in Latinx parents could potentially contribute to how parents socialize their children to cope. Parental directiveness/intrusiveness, protective parenting, and the high value of parent-adolescent communication seem especially relevant to understanding how parents might impact youth coping in this population. Given these unique patterns of parenting in this population and the high risk for depression, it seems especially important to investigate potential pathways by which parents might affect youth coping in this specific population. Second, there is preliminary evidence that parental coping suggestions are associated with youth coping, youth depressive symptoms, and parenting, but a cohesive theoretical model that integrates these relationships has not been proposed. Third, limited research has examined the impact of primary and secondary control coping suggestions separately on youth coping. Lastly, existing studies using the SOC have relied on single-informant data, and have not included child-report of coping suggestions.

Age

Age has been found to be associated with several of the variables in the current study. Perhaps most notably, prevalence rates of depressive symptoms change across the lifespan. The prevalence of depressive symptoms has been found to rise dramatically between the ages of 13 to 18 years (Kessler et al., 2005), and is two to four times as high in older than younger adolescents (Avenevoli et al., 2015).

The development of coping skills across the lifespan is not yet well understood, in large part due to the wide variability of assessment tools used in the field (Zimmer-Gembeck & Skinner, 2011). In general, children's specific *methods* of coping vary more by age than the coping styles they use (Zimmer-Gembeck & Skinner, 2011). Primary control coping skills have been found to emerge as early as toddlerhood, and behavioral forms of secondary control coping are thought to emerge in early childhood (Skinner & Zimmer-Gembeck, 2010). Children's use of cognitive coping skills in general (not a specific coping style) are thought to increase around middle childhood as they become more self-reliant, their metacognitive skills develop, and their emotion-regulation skills improve (Zimmer-Gembeck & Skinner, 2011). Cognitive abilities related to coping have been found to especially improve, diversify, and become more flexible between childhood and adolescence (Skinner & Zimmer-Gembeck, 2007, 2010; Thompson & Goodman, 2010; Zimmer-Gembeck & Skinner, 2011). Cognitive secondary control coping skills are thought to develop in late childhood (Skinner & Zimmer-Gembeck, 2010), and there is evidence that children use secondary control coping skills less often than adults due to the cognitive complexity (Power, 2014). There is also some evidence that disengagement coping decreases in middle childhood (Zimmer-Gembeck & Skinner, 2011). The meta-analysis by Compas et al. (2017) suggests that age may also be a significant moderator for the association between engagement coping and internalizing symptoms. Specifically, there may be a negative association between engagement coping and internalizing symptoms for adolescents, but not for children. Coping researchers have suggested that early and middle adolescence is a key period for studying how coping predicts the development of depression (Compas et al., 2017).

Existing research has also found that family financial stress may have a larger impact on adolescents' functioning than that of younger children (Conger et al., 2000). Conversely,

researchers have found that maternal depression has a larger effect on internalizing and externalizing symptoms in younger children compared to older children (Goodman et al., 2011).

Lastly, some researchers have found that Latinx parents use more hostile control with older children (e.g., Calzada & Eyberg, 2002; Halgunseth, Ispa, & Rudy, 2006; Hill, Bush & Roosa, 2003). Authors have theorized this may be because Latinx parents view misbehavior in older children as willful disobedience. These findings suggest that the age of the child should be taken into consideration when exploring the relationships among parenting, coping suggestions, youth coping, and youth depressive symptoms.

Gender

Gender has also been found to be associated with several of the described variables. Perhaps most importantly, the rates of depressive symptoms have been consistently shown to differ greatly by gender in adolescence, with females being two to three times as likely as males to develop depression (Avenevoli et al., 2015), including in Latinx samples (Zayas & Pilat, 2008). Girls have been found to have higher rates of maladaptive thinking patterns than boys, including unproductive rumination about negative events (e.g., Nolen-Hoeksema & Girus, 1994) and a negative attributional style that places excessive blame on the self (e.g., Hyde et al., 2008). In addition, a meta-analysis found that maternal depression is more strongly associated with internalizing symptoms in girls regardless of age compared to boys (Goodman et al., 2011).

There is some evidence that family financial stress may impact boys and girls differently. In families facing financial stress, the social-emotional and academic functioning of girls has been found to be directly impacted by both mothers' and fathers' depressed mood (Conger et al., 2000). In contrast, the same study found that no area of functioning for boys was directly affected by parents' mood.

Interestingly, research suggests there are not significant differences in the parenting of boys and girls. A meta-analysis of 126 observational studies with 15,034 families did not find significant differences in mothers' or fathers' use of autonomy-supportive and autonomy-controlling strategies with boys and girls (Endendijk, Groeneveld, Bakermans-Kranenburg, & Mesman, 2016). Parenting style has also not been found to differ by child gender in families of Mexican descent (Varela, et al., 2004).

There is some evidence that coping may vary by gender, with some research suggesting that males may be more likely to use disengagement coping and females more likely to use primary control coping strategies (Nicolotti et al., 2003). However, findings are inconsistent (Ayers, Sandler, West, & Roosa, 1996; Lazarus, 2006; Wadsworth & Berger, 2006; Wadsworth, Raviv, Compas, & Connor-Smith, 2005). A study by Weisz, Francis, and Bearman (2010) found there was not a significant association between gender and secondary control coping. However, they did find a gender difference in the strength of the relationship between secondary control and depressive symptoms: for boys, primary control coping was more protective against depressive symptoms than secondary control, and the opposite was true for girls (Weisz, Francis, & Bearman, 2010).

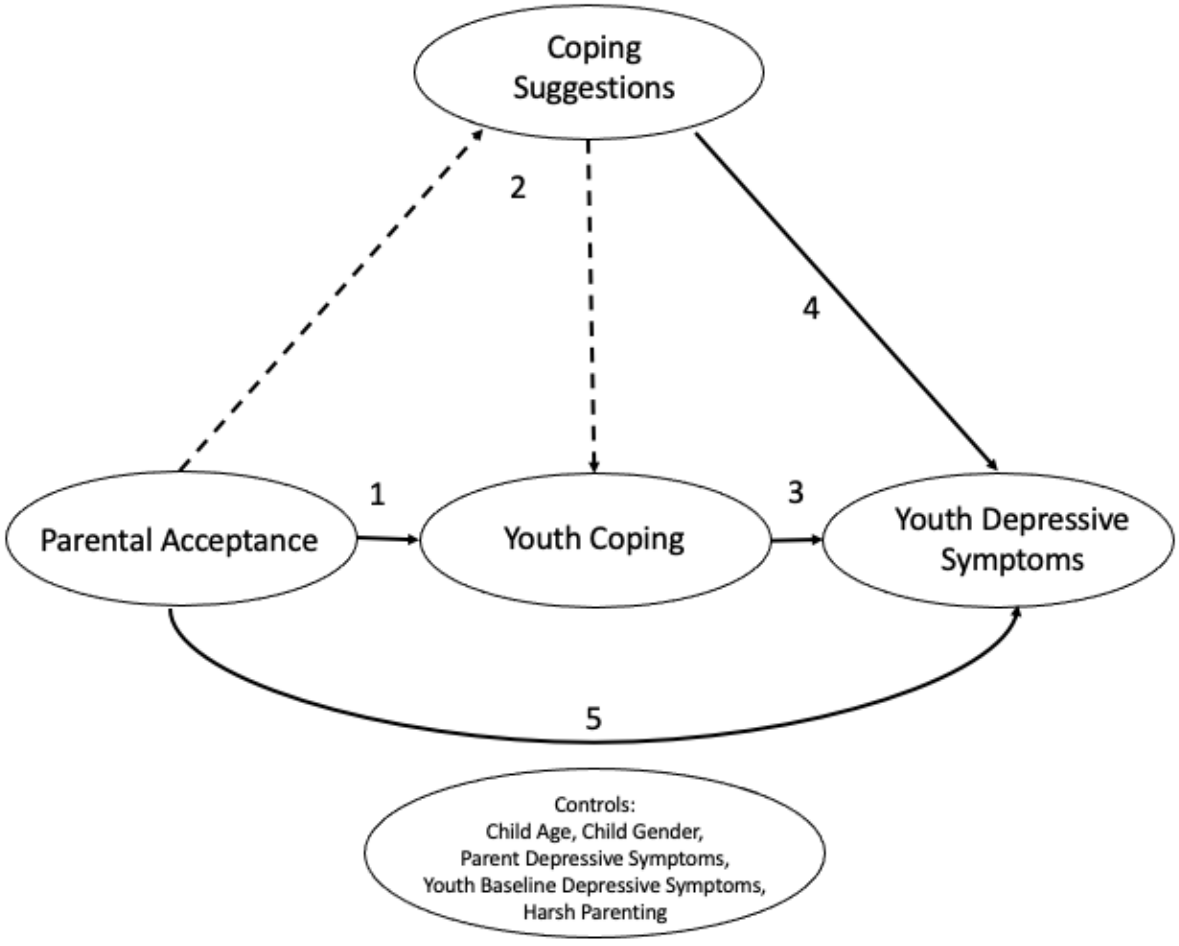
Some have suggested that the relationship between coping and depressive symptoms may also vary by gender, particularly depending on developmental stage (e.g., Carlson & Grant, 2008; Sontag & Graber, 2010). Primary control coping with family conflict, specifically, has been found to be protective against internalizing symptoms for girls in low-income families, but not boys (Santiago & Wadsworth, 2009). These findings suggest that the gender of the child should be taken into consideration when exploring the relationships among parenting, coping suggestions, youth coping, and youth depressive symptoms.

The Present Study

The present study tests a conceptual model that integrates previous theoretical models, empirical findings, and gaps in the existing literature described above. The conceptual model describes the relationships among parental acceptance, parent suggestions for coping with family conflict, youth coping with family conflict, and youth depressive symptoms in Latinx families after controlling for parental depressive symptoms, harsh parenting, child age, child gender, and youth depressive symptoms at baseline.

Figure 5

Proposed Conceptual Model



Note. Numbers represent the research question associated with the given path. Solid lines indicate hypothesized direct effects; dashed lines indicate hypothesized indirect effect.

The present study will address the following research questions:

Research question 1: Does parental acceptance predict how Latinx youth cope with family conflict?

Hypothesis 1: Parental acceptance will predict youth coping as follows:

a) Parental acceptance will be positively associated with primary control youth coping.
b) Parental acceptance will be positively associated with secondary control youth coping.
c) Parental acceptance will be negatively associated with disengagement youth coping.

Research question 2: Do parental coping suggestions mediate the relationship between parental acceptance and youth coping with family conflict for Latinx youth?

Hypothesis 2: Parental coping suggestions will mediate the relationship between parental acceptance and youth coping as follows:

a) Primary control coping suggestions will positively mediate the relationship between parental acceptance and primary control youth coping.
b) Secondary control coping suggestions will positively mediate the relationship between parental acceptance and secondary control youth coping.
c) Disengagement coping suggestions will positively mediate the relationship between parental acceptance and disengagement youth coping.

Research question 3: Does how Latinx youth cope with family conflict predict youth depressive symptoms?

Hypothesis 3: Youth coping will predict youth depressive symptoms as follows:

a) Primary control youth coping will negatively predict youth depressive symptoms.
b) Secondary control youth coping will negatively predict youth depressive symptoms.

c) Disengagement youth coping will positively predict youth depressive symptoms.

Research question 4: Do parent suggestions for how to cope with family conflict predict depressive symptoms in Latinx youth?

Hypothesis 4: Parental coping suggestions will predict youth depressive symptoms as follows:

a) Primary control coping suggestions will negatively predict youth depressive symptoms.
b) Secondary control coping suggestions will negatively predict youth depressive symptoms.
c) Disengagement coping suggestions will positively predict youth depressive symptoms.

Research question 5: Does parental acceptance predict depressive symptoms in Latinx youth?

Hypothesis 5: Parental acceptance will negatively predict youth depressive symptoms.

Chapter 2: Methods

Participants

The present research study[4] includes 92 Latinx families living in a large urban area in central Texas who participated in a larger longitudinal investigation of youth bilingual language development and mental health. Participating children and their parents were eligible if parents reported their child was Latinx or Hispanic, the child was between the ages of 10 and 15 years old at the start of the study, and parents identified the child as having at least minimal proficiency in both English and Spanish. The developmental period of ages 10 through 15 years old was selected due to existing research identifying early and middle adolescence as the key period for studying how coping predicts the development of depressive symptoms (Compas et al., 2017). Only one child and one caregiver from each family were permitted to participate. Youth language ability is not relevant to the present study, but was a requirement for the original study sample. The present study focuses on a subset of participants that completed specific measures.

Participants were recruited from schools and community events based on the high percentage of low-income Latinx families served. Due to the demographics of local school districts, the majority of participating families were recruited from charter schools. Participating schools had student bodies that are over 90% Latinx and over 80% eligible for free or reduced lunch. The research team provided a description of the study to selected school principals and obtained consent to describe the study to caregivers and students of the eligible age range. The

[4] This document – especially the literature review and methods sections – was influenced by this author's master's thesis: Moats, G.E. (2018). *The associations among parenting, socialization of coping, youth coping and youth depression in low-SES Latinx families*. [Master's thesis, University of Texas at Austin]. University of Texas Libraries. In addition to writing both manuscripts, this author assisted with collecting and analyzing the data that is referenced in both papers.

researchers provided a form to interested families that included a description of the study in English and Spanish, as well as the option for parents to indicate if they would like to be contacted regarding participation in the study. At community events (e.g., neighborhood back-to-school events, community picnics), researchers provided the same form to interested families. Bilingual members of the research team then contacted interested families via phone, described the study in more detail, and scheduled a first assessment with the family at their earliest availability.

Participating youth were 10 to 15 years of age (*M*=11.91), the modal age was 11, and youth ranged from 5th to 10th grades. A slight majority of youth were male (57.6%) and one youth identified as nonbinary; the remainder were female. According to parent-report, 45.7% of youth were racially White, 1.1% Black, 51.1% identified their child as "other", 2.2% did not report their child's race, and 100% identified their child as ethnically Hispanic/Latinx. Of the participating caregivers, 98.9% were biological parents, 96.7% were female, and one participating caregiver was a grandparent. Caregivers ranged in age from 27 to 55 years (*M*=38.99); 42.4% of caregivers identified as White, 55.4% as "other", and 2.2% did not report their race. Most caregivers were born outside of the U.S. (91.3%), 6.5% were 2nd generation American, and 2.2% were 4th generation and above. Most participating caregivers chose to complete measures in Spanish (90.2%). The majority of caregivers were of Mexican descent (91.3%), but a few caregivers were of Honduran (2.2%), El Salvadorian (2.2%), Nicaraguan (1.1%), and Venezuelan (1.1%) descent. Existing research has found that country of origin may play a role in predicting parenting and the relationship between parenting and youth depressive symptoms (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012; De Von Figueroa-Moseley,

Ramey, Keltner, & Lanzi, 2006), so results will be interpreted in the context of the heterogeneity of the participants' country of origin.

Poverty level is determined by family size, and research suggests that families need an income of about twice the federal poverty level to meet their basic needs. Families whose annual gross income is less than 200% of the federal poverty level (FPL) are considered to be "low income" (National Center for Children in Poverty, 2018). The average size of Latinx families in the U.S. has recently been found to be 3.25 (U.S. Census Bureau, 2016). In the present sample, family size ranged from 2-10 people, and the modal number of people living in participating families' homes was four (M=5.02). The 2018 federal poverty level for families with four household members in the 48 contiguous states was $25,100 (U.S. Census Bureau, 2018). In the current study, families' annual gross income was on average between $20,000 and $40,000, and the modal annual family income was between $20,000 and $30,000. Income ranged from under $10,000 to $80,000, with one family reporting income over $100,000. Of the participating families, 87.9% reported an annual gross family income below $50,000, which is roughly 200% of the federal poverty level for families with four household members (U.S. Census Bureau, 2018). According to parent report, 71.7% of children were eligible for free lunch and 14.1% for reduced lunch. Participating parents reported completing between one and 18 years of education. The mean level of education was 10th grade, and the mode was 12th grade. Given participants' responses on these variables, this sample of families was generally considered to be low-SES.

Procedure

Data collection for the present study began in November of 2016 and was completed in January of 2020. Data collection was not impacted by the COVID-19 pandemic. The present study is longitudinal, with the bulk of the data collected at Time 2. Data were collected at three

time points, each six months apart. At Time 1, (1) parent-report of demographic variables, (2) parent self-report of parent depressive symptoms, and (3) parent- and child-report of youth baseline depressive symptoms were collected. At Time 2, (1) parent- and child-report of parenting, (2) parent- and child-report of parental coping suggestions, and (3) parent- and child-report of youth coping were assessed. At Time 3, only parent- and child-report of outcome youth depressive symptoms was collected. This timeline was selected in order to minimize the burden on participants while still retaining important methodological features. By measuring the outcome variable (youth depressive symptoms) six months after measuring parenting, coping suggestions, and youth coping, results of the study could provide information about the possible direction of the relationship between youth depressive symptoms and each of these predictor variables in this population. In addition, assessing both parent and youth depressive symptoms at Time 1 allowed for relationships between variables to be examined while controlling for the possible effect of parent depressive symptoms and baseline youth depressive symptoms.

All assessments were conducted in-person. Youth completed all measures in English, and caregivers were permitted to choose whether to complete their assessments in Spanish or English. Participants were given the option of completing assessments in their homes or at the research office located on a university campus. Participants were compensated for their time with cash, and payments were proportional to the average length of the assessment at each time point. Given that Time 1 required the most time, parents and children were each compensated $25 for participation at Time 1. Time 2 required about half as much time as Time 1, so parents and children were each compensated $20 at Time 2. Time 3 required the least amount of time, so parents and children were each compensated $5 at Time 3. In total, each participant received $50 for their participation in all three time points of the study.

Aside from demographic variables and parent depressive symptoms, all variables were assessed using both parent- and child-report. This methodology was selected due to evidence that parent- and youth-report of youth mental health often differ. This has led researchers to recommend the use of multiple informants whenever possible to reduce mono-informant error (Achenbach, McConaughy, & Howell, 1987; Lau, Garland, Yeh, Mccabe, Wood, & Hough, 2004). In the parenting literature specifically, researchers have recommended that assessment of parenting behavior include multiple informants (Schwarz, Barton-Henry, & Pruzinsky, 1985). In addition, researchers have found that reports from knowledgeable informants (e.g., child-report, parent-report) are as valid as direct observations of parenting (Golden, 1969; Schwarz, Barton-Henry, & Pruzinsky, 1985). Given these previous findings, the researcher chose not to include direct observations of parenting, but instead collect parent- and child-reports of parent behavior.

Measures

Translation method. Several of the measures used in the present study were previously translated and validated in Spanish by other research teams (i.e., Child Behavior Checklist, Youth Self-Report, Beck Depression Inventory II, and Children's Report of Parent Behavior Inventory). Measures that had not been previously validated in Spanish (i.e., Response to Stress Questionnaire and Socialization of Coping) were translated and back translated twice by the bilingual research team members to ensure the content of the questionnaires remained the same. Back translation has been supported as an adequate technique for reducing errors in translated materials (Brislin, 1970).

Demographic variables. Parents were asked to report their child's age and gender and several variables related to SES on a Demographic Form developed by the research lab for the larger research study. Parents were asked to indicate their current annual gross family income

using a multiple-choice format in increments of $10,000, as well as parent education level, parent employment status, number of rooms and people in the home, home address, child's school, and child's eligibility for free or reduced lunch, Medicaid, and the Children's Health Insurance Program (CHIP). These variables were only utilized in the present study to better understand the sample through descriptive analyses. The Demographic Form assesses a range of other demographic variables not included in the present study.

Youth Depressive Symptoms. Youth depressive symptoms were assessed using subscales of the Youth Self-Report (YSR; completed by youth) and the Child Behavior Checklist (CBCL; completed by parents). The YSR and CBCL ask youth and parents (respectively) to report on a range of child emotional and behavioral symptoms during the previous six months. Both of these measures are part of the widely-used Achenbach System of Empirically Based Assessment (ASEBA; Achenbach, Rescorla, & Maruish, 2004) which measures internalizing, externalizing, social, and thought problems in youth, as well as strengths. The ASEBA has long-standing evidence of excellent internal consistency and test-retest reliability for each of its measures (Cronbach's alphas all greater than $\alpha = .75$), as well as good construct validity (Achenbach et al., 2008). Normative samples for the YSR and CBCL are representative of the U.S. population, providing adequate data on levels of emotional and behavioral problems in racial and ethnic minority youth. The ASEBA is the most widely-used broad-band measure of social-emotional functioning in youth in research. ASEBA scales have been translated into over 100 languages, have been used in research in over 50 countries and societies, and have evidence of cross-cultural validity (Achenbach, 2019; Achenbach et al., 2008). Unlike other similar measures, the ASEBA has been both translated and normed in Spanish, and has additionally demonstrated cross-cultural validity with youth in Mexico (Albores-Gallo, et al., 2007) and Puerto Rico (Achenbach, 2019).

A study of 31 countries and cultures found that distributions of Total Problems on the CBCL were similar across cultures (Achenbach, 2019). However, the study also found that parents in Puerto Rico reported the highest mean Total Problems score compared to other countries in the study (Achenbach, 2019). Researchers have also found that scores on the ASEBA scales that tap into internalizing symptoms vary more across cultures than scales that measure externalizing symptoms, with the most variability found for the Anxious/Depressed scale (Achenbach et al., 2008). No other Central or South American countries were included in this study.

For the purposes of the present study, all six ASEBA subscales that have been found to tap into youth depressive symptoms were administered to both parents and youth: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Depressive Problems, Somatic Problems, and Internalizing Problems scales. The Anxious/Depressed (13 items), Withdrawn/Depressed (8 items), and Somatic Complaints (11 items) scales are considered "empirically-based" ASEBA scales because they are made up of items that have been found to co-occur across many cross-cultural research participants using confirmatory factor analysis (Achenbach, Rescorla, & Maruish, 2004). In contrast, the Depressive Problems (13 items) and Somatic Problems (7 items) scales are "DSM-oriented" ASEBA scales, meaning they are comprised of items that were identified by experts to be consistent with symptoms of psychological disorders from the Diagnostic Statistical Manual, 5th edition (DSM-5). Because the empirically-based ASEBA scales have been found to have better internal consistency than the DSM scales, researchers generally recommend using the former (Achenbach et al., 2008). Lastly, the Internalizing Problems scale is a sum of the empirically-based Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints scales, and is therefore considered a "broadband" ASEBA scale that taps into both anxious and depressive symptoms (Achenbach,

Rescorla, & Maruish, 2004). The Internalizing Problems scale has been found to have even stronger internal consistency than the empirically-based scales (Achenbach et al., 2008). Depending on the results of preliminary analyses, specific ASEBA subscales will be selected as the outcome variable(s) for use in model analyses. Items from the ASEBA scales selected for path analyses are included in Appendix A.

Youth Coping. Parents and youth completed the parent-report and child self-report versions of the Responses to Stress Questionnaire (RSQ) – Family Stress Version. The RSQ is designed to capture the ways that individuals respond to specific sources of stress (e.g., academics, cancer, parent depression). The Family Stress Version of the RSQ was selected due to the focus of the study on the influence of family conflict on coping. The RSQ contains 57 items and asks individuals to report on the child's coping over the previous six months. Informants rate how frequently a child has responded in a given way to the stressor of interest on a scale of 1 to 4, where 1 is "not at all" and 4 is "a lot." In order to account for individual differences in rates of endorsing items, the relative proportion of each type of coping reported is calculated for each respondent.

The RSQ is based on Compas and colleagues (2001) model of coping, which is one of the most commonly used measures of coping (Compas et al., 2017). Factor modeling suggests the RSQ has among the strongest construct validity of existing coping measures (Compas et al., 2017; Connor-Smith et al., 2000). Confirmatory factor analyses of the RSQ have identified five factors: (1) engagement coping, (2) primary control coping, (3) secondary control coping, (4) disengagement coping, and (5) involuntary stress response (Connor-Smith et al., 2000). Both primary and secondary control coping are subtypes of engagement coping, and involuntary stress responses are not volitional efforts to cope with a stressor. These factors have been confirmed by

six independent studies on seven samples faced with a variety of stressors (Benson et al., 2011; Compas et al., 2006; Connor-Smith et al., 2000; Wadsworth, Rieckmann, Benson, & Compas, 2004; Xiao et al., 2010).

The RSQ has demonstrated good internal consistency, test-retest reliability, and convergent and discriminant validity (Compas et al., 2017; Connor-Smith et al., 2000). In previous studies, internal consistencies of the factors have been estimated to range from α=.67 to α=.84 (Compas et al., 2017). Though the RSQ has not been validated with Latinx populations, it has shown the same factor structure and good reliability and validity with ethnically diverse samples (Compas et al., 2006; Connor-Smith et al., 2000; Wadsworth et al., 2004; Connor-Smith & Calvete, 2004; Benson et al., 2011; Xiao et al., 2010). The RSQ is also one of the few measures of coping with both parent- and child self-report versions available, and has demonstrated cross-informant correlations (Compas et al., 2017). This measure was translated into Spanish by the present bilingual research team using the back-translation method described above. For the current sample, internal consistencies for the parent-report data were as follows: Engagement Coping α=.87, Primary Control Coping α=.81, Secondary Control Coping α=.84, Disengagement Coping α=.74, and Involuntary Response α=.94. For the child-report data were as follows: Engagement Coping α=.90, Primary Control Coping α=.86, Secondary Control Coping α=.85, Disengagement Coping α=.80, and Involuntary Response α=.95. The English child-report version of the RSQ is included in Appendix B and Spanish parent report of the RSQ is included in Appendix C for reference.

Parental Coping Suggestions. Parents and youth completed the parent-report and child self-report versions of the Socialization of Coping (SOC) measure. It was adapted to assess coping suggestions specific to family conflict by including a prompt at the beginning that defines

and asks about family conflict, similar to the RSQ-Family Stress Version. The SOC measure was developed by Abaied and Rudolph (2010) and assesses the ways in which parents socialize their children towards certain coping behaviors by making direct coping suggestions. It is important to note that despite the broad title of this measure, it only assesses one of the ways in which parents socialize their children to cope (coping suggestions) and does not assess any other ways in which parents socialize their children's coping (i.e., modeling, reinforcement, or family environment). Parents and adolescents in the present study each completed the 17-item SOC questionnaire which asks individuals to report on parental coping suggestions during the previous six months. The measure includes questions such as, "When your child has a problem or is upset, how much do you do each of the following?" Parents and youth rate each item on a five-point scale, where 1 means "not at all" and 5 means "very much." In contrast to scoring for the RSQ that calculates relative proportion scores, a mean score is calculated for each type coping suggestion.

The SOC is based on Compas' (2001) empirically-supported Five Factor Model of Coping and the RSQ (described above). Relevant questions were reworded slightly by previous researchers to apply to parent coping suggestions rather than youth coping behaviors. Because the measure was intended to assess parents' suggestions for coping, items related to involuntary responses to stress are not included in the measure. Confirmatory factor analysis of the SOC parent-report has found that it aligns with the Compas (2001) model of coping and taps into two latent variables: engagement coping suggestions (which includes both primary and secondary control coping suggestions) and disengagement coping suggestions. The SOC parent-report was found to have adequate reliability (engagement $\alpha = .87$; disengagement $\alpha = .89$). The authors found that maternal-report on the SOC has strong temporal stability for both

engagement suggestions, $r = .71$, $p < .001$, and disengagement suggestions, $r = .73$, $p < .001$. They also found evidence of predictive validity through findings that mothers' coping suggestions predict youth psychopathology in the context of stress (Abaied & Rudolph, 2010b). No research has yet been published on the psychometric properties of the child-report version of the SOC. This measure was also translated into Spanish by bilingual research assistants using the back-translation method. For the current sample, internal consistencies for the parent-report data were as follows: Engagement Coping Suggestions α=.95, Primary Control Coping Suggestions α=.92, Secondary Control Coping Suggestions α=.90, and Disengagement Coping Suggestions α=.88. Internal consistencies for the child-report data were as follows: Engagement Coping Suggestions α=.93, Primary Control Coping Suggestions α=.90, Secondary Control Coping Suggestions α=.88, and Disengagement Coping Suggestions α=.88. The English child-report version of the SOC is included in Appendix D and Spanish parent report of the RSQ is included in Appendix E for reference.

Parenting. The Parental Acceptance and Harsh Parenting subscales from the Children's Report of Parent Behavior Inventory (CRPBI) were administered to parents and children as measures of parenting behaviors. The CRPBI is perhaps the most widely used measure of parenting behavior, and there is strong evidence for its reliability and cross-cultural validity (e.g., Barrera et al., 2002; Hill, Bush, & Roosa, 2003; Nair, White, Knight, & Roosa, 2009). The rating scale measure was originally developed by Schaefer (1965) to capture children's perceptions of their parents' child-rearing behavior. It has since then been converted into a parent-report measure, translated into Spanish, and revised into shorter versions that still capture the same three factors but are more acceptable to users.

The Parental Acceptance scale from the CRPBI has been especially widely used in parenting research, and has demonstrated adequate internal consistency (α = .67 to .88) and cross-cultural validity for the child- and parent-report versions in Spanish and English with Mexican, Central American, South American, and Caribbean individuals of varying generational statuses (Barrera et al., 2002; Hill, Bush, & Roosa, 2003; Knight, Tein, Shell, & Roosa, 1992; Nair, White, Knight, & Roosa; 2009; Varela et al., 2009, 2013). This scale was selected for the present study as the measure of warm, responsive parenting.

Multiple studies with Latinx samples have found that the Hostile Control scale from the original CRPBI measure does not have adequate internal consistency for Latinx samples (Hill, Bush, & Roosa, 2003; Knight, Tein, Shell, & Roosa, 1992; Varela et al., 2009). For example, Knight, Tein, Shell, and Roosa (1992) found that the child-report version of the Hostile Control scale had very poor fit for Latinx children (BBNN and CFI indexes were less than .60).[5] In addition, in Varela et al.'s (2009) study of 7- to 16-year-old youth, they found low internal consistency for the child-report of Hostile Control in their sample of Mexican nationals. Given this, Nair, White, Knight, and Roosa (2009) modified the Hostile Control scale of the CRPBI to be more appropriate for Latinx samples and called it "Harsh Parenting." These researchers created a parent-report version as well, translated it into Spanish, and tested the equivalence of the new measures with Spanish- and English-speaking Mexican American families using confirmatory factor analysis (CFA). They found similar factor structures across language groups for both mothers and children, as well as adequate internal consistency for the Harsh Parenting

[5] Bentler-Bonnet non-normed fit indexes (BBNN) and comparative fit indexes (CFI) that describe the discrepancy between the data and hypothesized model. BBNN and CFI values range from 0 to 1, with values of .90 and above considered good fit, between .80 and .89 considered adequate, between .60 and .79 considered poor, and below .60 considered very poor fit.

scale (mother report α = .70; child report α =.73). Given the evidence that harsh parenting is associated with positive youth outcomes only when paired with warm/responsive parenting (e.g., White et al., 2013), the Harsh Parenting scale was selected as a control variable in the present study.

The Parental Acceptance and Hostile Control/Harsh Parenting subscales have been studied more widely than the third subscale of the CRPBI, the "Inconsistent Discipline" scale (Barrera et al., 2002; Varela et al., 2009, 2013). The Parental Acceptance and Hostile Control/Harsh Parenting subscales have also previously been found to be strong predictors of youth coping (Kliewer, Fearnow, & Miller, 1996) and youth depressive symptoms (Hill, Bush, & Roosa, 2003) across racial and ethnic groups. There is less evidence to suggest that Inconsistent Discipline is associated with depressive symptoms in Latinx youth (Roosa, Tein, Groppenbacher, Michaels, & Dumka, 1993). Due to this, only the Parental Acceptance and Harsh Parenting subscales of the CRPBI were administered in the present study. One item from this scale ("Your parent spanked or slapped you when you did something wrong") was omitted due to concerns that it could elicit information that would ethically require researchers to report possible child abuse. For the current sample, internal consistencies for the parent-report data were as follows: Parental Acceptance α=.88 and Harsh Parenting α=.81. Internal consistencies for the child-report data were as follows: Parental Acceptance α=.92 and Harsh Parenting α=.81. The English child-report version of the CRPBI is included in Appendix F and Spanish parent report of the CRPBI is included in Appendix G for reference.

6. Parental Depressive Symptoms. Parental depressive symptoms were assessed using the Beck Depression Inventory II (BDI-II). The BDI-II is a 21-item self-report multiple-choice inventory. It is widely used and available in many languages, including Spanish. Items are rated

on a 4-point scale ranging from 0 to 3 on severity. Raw scores from 0-13 indicate minimal depressive symptoms, scores from 14-19 indicate mild depressive symptoms, scores from 20-28 indicate moderate depressive symptoms, and scores from 29-63 indicate severe depressive symptoms (Beck et al., 1961). Internal consistency for the English version of the BDI-II ranges from .73 to .92 with a mean of .86 (Beck, Steer, & Garbin, 1988). Research using the Spanish translation of the BDI-II has found high internal consistency (α = .87 to .92), adequate one-week test-retest reliability (ICC = .86), adequate model fit, and no significant differences between English and Spanish versions in their sample of bilingual individuals (González, Rodríguez, & Reyes-Lagunes, 2015). The BDI-II is one of the few measures of depressive symptoms that has demonstrated empirical validity with Spanish-speaking Latinx samples (Limon et al., 2016). For the current sample, internal consistency was α=.91.

Participant Retention

Of the 92 families that participated in Time 1 of the present study, 83 parents and 85 youth went on to complete Time 2, and 81 parents and 82 youth completed Time 3. Three families that participated at Time 3 had missing data at Time 2 (two families skipped Time 2 entirely, one family was only missing parent data). For one family, the child but not the parent was available to complete both the Time 2 and Time 3 assessments. The result was 78 parents and 80 youth that completed all measures for all time points of the present study. A timeline of the measures administered and participants retained at each time point is presented below in Table 1.

Table 1

Timeline of Measures and Retention of Participants

Time 1	Time 2	Time 3
92 Parents & 92 Youth	**83 Parents & 85 Youth**	**81 Parents & 82 Youth**
Child Gender *(control)*	Harsh Parenting *(control)*	Outcome Youth Depressive Symptoms
Child Age *(control)*	Parental Acceptance	
Parent Depressive Symptoms *(control)*	Coping Suggestions	
Baseline Youth Depressive Symptoms *(control)*	Youth Coping	

Power Analysis

Though the proposed theoretical models would best be tested using structural equation modeling (SEM) due to the ability to account for measurement error using latent variables, the current sample is too small to provide adequate power for SEM. When using SEM, it is generally recommended that one have at least five to ten cases for each estimated parameter (Wolf et al., 2013). The proposed model that includes direct effects between all four study variables and all five control variables results in 45 parameters requiring estimation. This model would require 225 to 450 participating families to provide adequate power for SEM, many more than the current sample.

Given this, path analysis of observed variables was used instead to examine hypothesized relationships among variables. Path analyses can only be run with cases that are not missing data on any covariate (i.e., predictor or independent) variables. For the proposed model, the five control variables are considered predictor variables. Therefore, only parent and child cases that had data for all five control variables were determined to be usable in analyses. Of the 92 families that participated, 82 parents and 84 youth completed measures of all independent (i.e.,

control) variables and were therefore usable in path analyses. A power analysis using the Monte Carlo feature in *Mplus* Version 7 (Muthén & Muthén, 2012) was run to determine whether 82 cases would provide sufficient power for path analysis of the proposed model. Given previous findings in the extant literature regarding relationships between variables, analyses were run using a partial regression coefficient of 0.39 for each direct effect, which is an estimate of a moderate effect size ($f^2 = 0.15$; Faul, Erdfelder, Lang, & Buchner, 2007). The Monte Carlo power analysis indicated that the probability of correctly rejecting the null hypothesis for each direct effect at the .05 level using a sample of 82 participants ranged from .896 to .997. Using the commonly accepted value of .80 as indicating adequate power (Muthén & Muthén, 2002), these results suggested that 82 participants would provide sufficient power for path analysis of the proposed model.

Preliminary Analyses

First, the number and percentage of cases with missing data were calculated, and independent samples T-tests were run to examine whether cases missing any dependent variable data differed significantly from cases with no missing dependent variable data.

Second, several analyses were run in order to inform the selection of ASEBA subscales to use as the outcome measures of youth depressive symptoms. Descriptive statistics (means, standard deviations, skewness, kurtosis) were run for each of the six ASEBA scales administered at Time 3: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Depressive Problems, Somatic Problems, and Internalizing Problems scales. Analyses were run using raw scores as opposed to T-scores in order to allow for maximum variability. Normality was inspected. To investigate convergent validity, correlations were also run between raw scores for each of these ASEBA scales administered at Time 3 and raw scores on another measure of youth

depressive symptoms completed by youth (not parents) at Time 3, the Center for Epidemiological Studies Depression Scale (CES-D).

Third, descriptive statistics (means, standard deviations, variances, and frequencies) for all study variables were examined and normality was assessed (skewness and kurtosis).

Lastly, Pearson correlations and t-tests were run. Pearson correlations between each study variable and all control variables were run in order to determine which control variables should be included within path models. Independent t-tests were conducted to investigate whether there were significant gender differences in any study variables. Pearson correlations were also run between each pair of study variables theorized to influence one another in the proposed path models. Parent- and child-report data were examined separately, and differences between parent- and child-report data were examined. In addition, correlations between parent- and child-report data were run to examine potential informant discrepancies. Since these were preliminary analyses and not hypothesis testing, analyses were not adjusted to account for multiple comparisons, and p-values were reported at multiple levels of significance.

Path Analysis

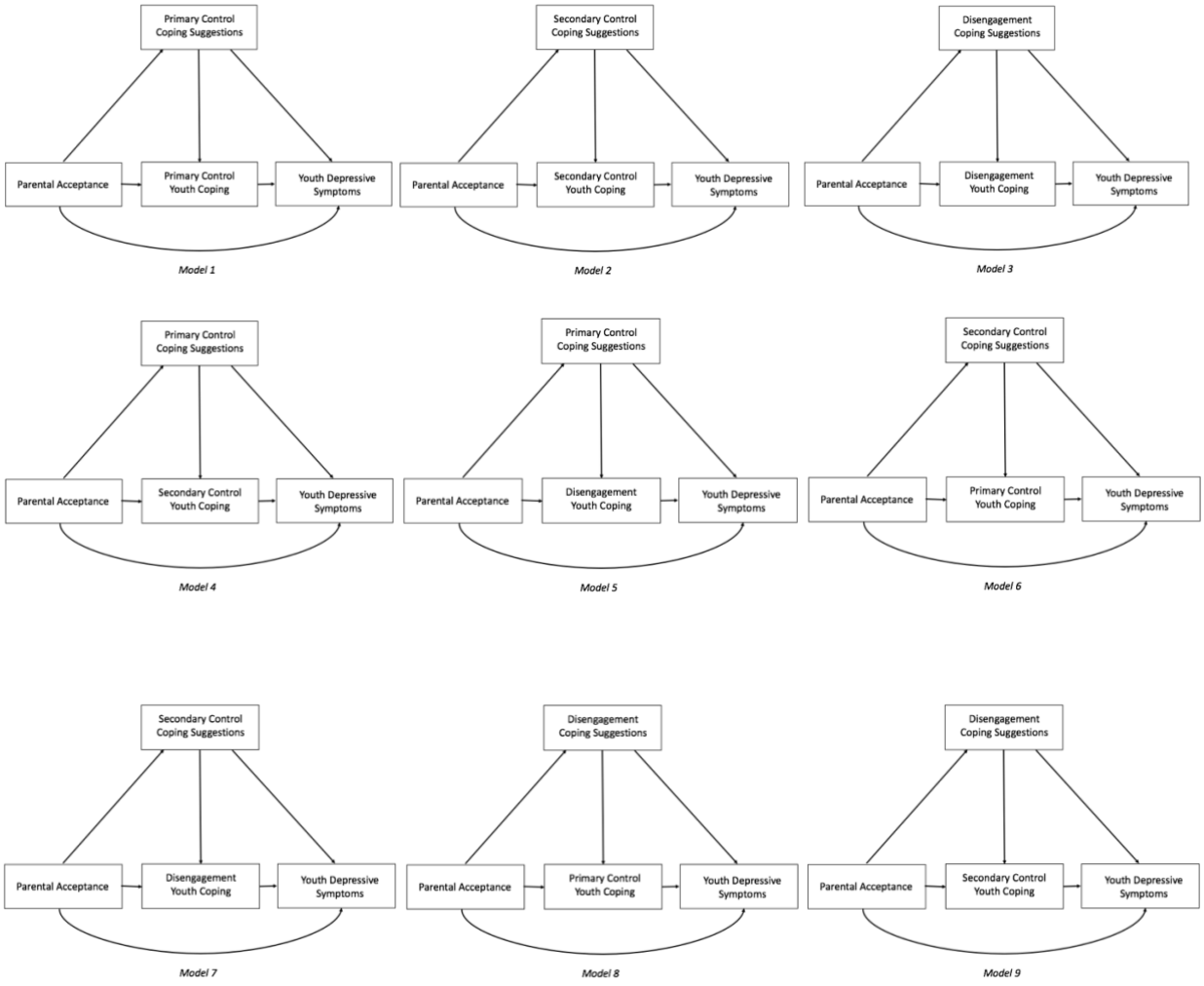
Path analysis uses aggregate scores for each variable as opposed to factors and removes the need to estimate path values for each item from administered measures. Path analysis is an extension of multiple regression that allows multiple dependent variables to be modeled simultaneously, as well as for tests of mediation. Therefore, compared to multiple regression analysis in which the same paths would need to be tested in multiple steps, path analysis allows for multiple direct and indirect paths to be tested simultaneously (Sanchez, Whittaker, & Hamilton, 2016). Direct effects in a path model are analogous to partial regression coefficients in a multiple regression analysis. Indirect effects are the product of coefficients for the direct paths

of interest. Bias-corrected bootstrapping was used to estimate whether indirect (mediation) effects were significant. Bootstrapping is commonly used for mediation analyses, and is particularly recommended with small sample sizes. Bootstrapping is a statistical technique in which random samples are drawn from the dataset and replaced in order to estimate a population parameter. Bootstrapping produces a confidence interval for the estimate, which provides more useful information about the parameter than a single p-value would. Because the mean of the distribution does not exactly equal the indirect effect, a bias correction is often used, and is particularly recommended when low power due to a small sample is a concern (Kenny, 2016). If zero does not fall within the 95% confidence interval of the upper and lower critical values for the distribution of indirect effect, the mediation effect is considered significant. The statistical modeling software *MPlus* Version 7 (Muthén & Muthén, 2012) was used to address the five research questions through path analysis.

Given that the present study aims to examine relationships among three distinct types of Youth Coping (Primary Control, Secondary Control, and Disengagement) and three types of Coping Suggestions (Primary Control, Secondary Control, and Disengagement), this results in a total of nine basic models for examination. Since researchers in the parenting field have generally recommended that parent and child data be analyzed separately due to low parent-child agreement on parenting measures (Tein, Roosa, & Michaels, 1994; White, Roosa, Weaver & Nair, 2009), separate models were run for parent and child data. In addition, separate models were run for each ASEBA subscale eventually selected as an outcome measure.

Figure 6

Nine Basic Conceptual Models



Within path analyses, full information maximum likelihood (FIML; often referred to simply as *maximum likelihood*) was used to account for missing data. FIML selects an estimate for each parameter that maximizes the probability that the observed data would occur. FIML uses all available data to estimate each parameter in the model without filling in missing values. FIML is the default estimator in *Mplus* and is recommended when observations are independent and data are presumed to be missing at random (MAR; Allison, 2001). Some have argued that

FIML is more adept at handling missing data than multiple imputation (MI) due to producing less biased estimates and smaller sampling variances (Allison, 2015). It is recommended over listwise deletion as it uses all available data rather than increasing bias by deleting cases, especially when data are MAR or missing not at random (MNAR; Enders, 2001).

Model fit for both parent- and child-report data was assessed using the Chi-square (x^2) test of conceptual and baseline model fit, the comparative fit index (CFI), the Tucker-Lewis Index (TLI), Standardized Root Mean Square Residual (SRMR), and the Root Mean Squared Error of Approximation (RMSEA).

Chapter 3: Results

Missing Data

As previously explained, path analyses can only be run with cases that are not missing data on any independent variables. Of the 92 families that participated in the present study, 82 parents and 84 youth completed measures of all independent (i.e., control) variables and were therefore usable in path analyses. Of those usable cases, 78 parents and 80 youth also completed measures of all dependent variables, and therefore had no missing data. This means of the cases that were usable in path analyses, 4.90% were missing some parent-report data and 4.76% were missing some child-report data.

Table 2

Number of Cases Used in Analyses that Completed Data for Each Variable

Variable	**Parent Cases**	**Child Cases**
T1 Child Age *(control)*	82	84
T1 Child Gender *(control)*	82	84
T1 Parent Depressive Symptoms *(control)*	82	84
T1 Baseline Youth Depressive Symptoms *(control)*	82	84
T2 Harsh Parenting (*control*)	82	84
T2 Parental Acceptance	82	84
T2 Coping Suggestions	82	84
T2 Youth Coping	82	84
T3 Outcome Youth Depressive Symptoms	78	80

In order to determine whether data were missing at random, independent samples T-tests were run to examine whether cases that were missing data for any variables differed significantly from cases with no missing dependent variable data. Two T-tests were run: one examining

missing parent-report data and one for missing child-report data. Results indicated that cases with any missing data were significantly more likely than those with no missing data to have higher scores of child-reported Baseline Anxious/Depressed symptoms (for cases missing parent-report data, $t(80) = -2.295$, $p=.024$; for cases missing child-report data, $t(82) = -2.295$, $p=.024$). Cases with any missing data were also significantly more likely than those with no missing data to have higher scores of child-reported Baseline Internalizing Problems (for missing parent-report data, $t(80) = -1.991$, $p=.050$; for missing child-report data, $t(82) = -2.007$, $p=.048$). Given that the Anxious/Depressed and Internalizing Problems scales are two of the outcome measures of interest, these results suggest that data cannot be considered missing completely at random (MCAR) and could be either missing at random (MAR) or missing not at random (MNAR; Eekhout, 2020). The limitations of this will be addressed in the Discussion. Since it is impossible to determine whether data are MAR or MNAR, for the purposes of this study, it will be assumed that data are MAR, and therefore FIML was used (Allison, 2001).

Selection of Measure for Youth Depressive Symptoms

In order to select a measure of youth depressive symptoms from the six relevant ASEBA subscales administered at Time 3, the following issues were considered: normality of distribution, convergent validity, internal consistency, and trends in the extant literature. Just as in multiple linear regression, dependent variables used in path analysis should be approximately normally distributed (Columbia Public Health, 2019). In general, absolute values greater than 3 indicate non-normality. In *SPSS* automated output analyses, skewness values greater than 1.0 and less than -1.0 indicate non-normal, asymmetrical distributions. Kurtosis values greater than 1.0 or less than -1.0 indicate the distribution is more “peaked” or “flat”, respectively, than normal (Hair, Anderson, Babin, & Black, 2010). Results of these analyses indicated that parent-report of

Outcome Somatic Complaints, Depressive Problems, and Somatic Problems had positive skewness and positive kurtosis (leptokurtic distribution). Parent-report of Outcome Anxious/Depressed, Withdrawn/Depressed, and Internalizing Problems were normally distributed. Skewness ranged from 0.70 to 2.03 (*SE*=.27) and kurtosis ranged from -0.23 to 4.62 (*SE*=.54). For the youth-report scales, only the Outcome Withdrawn/Depressed scale indicated a normal distribution; all other scales were positively skewed and leptokurtic. Skewness ranged from 0.79 to 2.85 (*SE*=.27) and kurtosis ranged from 0.25 to 10.27 (*SE*=.53). This means that on all scales except Outcome Withdrawn/Depressed, the sample of youth endorsed fewer than expected items, and scores tended to cluster around the middle values more than would be expected for a normal distribution. However, previous statisticians have argued that "even for distributions which depart markedly from non-normality, sums of 50 or more observations approximate to normality" (Bock, 1975, p. 111). This suggests that the sample of 78 parents and 80 youth assessed at Time 3 is large enough to limit the impact that non-normality could have on statistical tests (Stevens, 2012).

To investigate convergent validity, correlations were also run between raw scores for each of these ASEBA scales administered at Time 3 and raw scores on another measure of youth depressive symptoms completed by youth (not parents) at Time 3, called the Center for Epidemiological Studies Depression Scale (CES-D). The CES-D is a 20-item self-report measure that has demonstrated cross-cultural validity with Latinx youth (Crockett, Randall, Shen, Russell, & Driscoll, 2005). Scores of 16 and above on the CES-D indicate clinical levels of depressive symptoms (Locke & Putman, 1971). Internal consistency for the current sample on the CES-D was found to be $\alpha = .69$. All but one ASEBA scale was significantly correlated with the CES-D. For the parent-report ASEBA scales, Outcome Anxious/Depressed had the strongest correlation

with the CES-D (r = .492, p < .001), followed by Outcome Depressive Problems (r = .430, p <.001) and Outcome Internalizing Problems (r = .422, p < .001). For the child-report ASEBA scales, Outcome Internalizing Problems had the strongest correlation with the CES-D (r = .785, p < .001), followed by Outcome Anxious/Depressed (r=.779, p <.001) and Outcome Depressive Problems (r = .721, p < .001). Only parent-report of Outcome Withdrawn/Depressed was not significantly correlated with youth self-report on the CES-D (r = .218, p = .055). The lack of correlation between parent-report of Outcome Withdrawn/Depressed with youth self-report on the CES-D could be indicative of differences between parent and child perceptions of symptomatology (Achenbach, McConaughy, & Howell, 1987). Alternatively, the Withdrawn/Depressed scale might tap into a specific or different aspect of depressive symptoms than the CES-D and the other ASEBA scales examined. The majority of items on the Withdrawn/Depressed scale ask about social withdrawal symptoms, while the CES-D assesses a wider range of depressive symptoms. Items from the ASEBA scales that were ultimately selected for path analyses as well as the CES-D are included in Appendix A.

Table 3

Correlations Between CES-D and ASEBA Scales at Time 3

	Anxious/ Depressed	Withdrawn/ Depressed	Somatic Complaints	Depressive Problems	Somatic Problems	Internalizing Problems
Parent-Report	.49**	.22	.27*	.43**	.24*	.42**
Youth-Report	.78**	.61**	.64**	.72**	.57**	.79**

* p<.05, ** p<.01, *** p<.001

To summarize, youth-report of Outcome Withdrawn/Depressed and parent-report of Outcome Anxious/Depressed, Withdrawn/Depressed, and Internalizing Problems had normal distributions; all other ASEBA scales administered at Time 3 were positively skewed and leptokurtic. All ASEBA scales except parent-report of Outcome Withdrawn/Depressed were

significantly positively correlated with the CES-D measure of youth depressive symptoms. In addition, the Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, and Internalizing Problems scales have been found to have better internal consistency than the DSM scales, and researchers generally recommend using the former (Achenbach et al., 2008). Somatic symptoms have been found to be related to both anxiety and depression in Latinx youth, and are thought to be a non-specific symptom of distress (Varela & Hensley-Maloney, 2009). Lastly, no previous research could be identified that recommended a specific scale of the ASEBA should be used when assessing depressive symptoms in Latinx youth. Given all of this information, Anxious/Depressed, Withdrawn/Depressed, and Internalizing Problems were selected as the measures of youth depressive symptoms to be examined in model analyses. Items included in the Anxious/Depressed, Withdrawn/Depressed, and Internalizing Problems scales are included in Appendix A.

Other Preliminary Analyses

Frequencies of responses above the cut-off for clinical depression on the ASEBA subscales were examined to determine whether the measure of depressive symptoms should be dichotomized. For the narrowband scales (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Depressive Problems, and Somatic Problems), standardized T-scores of 70 and above are considered "clinically elevated" and T-scores between 65-69 are considered in the "borderline" range. For the broadband scale Internalizing Problems, T-scores of 64 and above are considered clinically elevated and T-scores between 60-63 are considered in the borderline range. Among the parent-report CBCL scales completed at Time 3, Outcome Internalizing Problems (7.69%), Somatic Problems (3.85%), and Somatic Complaints (3.85%) had the highest percent of cases above clinical cut offs. Among the youth-report YSR scales completed at Time

3, Outcome Internalizing Problems (11.25%), Withdrawn/Depressed (6.25%), Anxious/Depressed (5.00%), and Somatic Complaints (5.00%) had the highest percent of cases who scored above clinical cut offs. These results also indicate that on average youth reported a higher number of symptoms than parents, which aligns with previous research on informant discrepancies (Achenbach, McConaughy, & Howell, 1987). When comparing the results of scales selected for use in future analyses across parent- and child-report data, a higher percentage of cases scored above clinical cutoffs on the Internalizing Problems and Withdrawn/Depressed scales than on the Anxious/Depressed scale. It should be noted that due to the many statistical costs associated with dichotomizing continuous variables, participants were not grouped into clinical vs. subclinical groups (Altman & Royston, 2006), and measures of youth depressive symptoms were kept as continuous variables in analyses.

Table 4

Means and SDs for ASEBA T-scores at Time 3

Scale	Mean	SD
Parent-report Anxious/Depressed	53.49	4.87
Parent-report Withdrawn/Depressed	55.49	5.87
Parent-report Internalizing Problems	51.00	9.77
Child-report Anxious/Depressed	54.64	7.69
Child-report Withdrawn/Depressed	56.64	6.80
Child-report Internalizing Problems	52.03	10.31

Table 5

Percentages (and Total Numbers) of Cases Reporting Clinically Elevated ASEBA Scores at Time 3

	Anxious/Depressed	Withdrawn/Depressed	Internalizing Problems
Parent-Report	0.00% (0/78)	2.56% (2/78)	7.69% (6/78)
Youth-Report	5.00% (4/80)	6.25% (5/80)	11.25% (9/80)

Descriptive statistics for all remaining study variables were examined for normality and outliers. For the parent-report data, Baseline Withdrawn/Depressed, Baseline Anxious/Depressed, Baseline Internalizing Problems, and Parent Depressive Symptoms displayed positively skewed distributions, indicating that parents endorsed fewer than expected items on these scales. Parent-report of Primary Control Coping Suggestions displayed a negatively skewed distribution, meaning parents endorsed a greater number of items on this scale than expected. In addition, high positive kurtosis values for parent-report of Baseline Withdrawn/Depressed, Primary Control Coping Suggestions, Secondary Control Coping Suggestions, and Parent Depressive Symptoms indicated that scores tended to cluster around the middle values more than would be expected for a normal distribution. For the child-report data, only Baseline Anxious/Depressed and Baseline Internalizing Problems indicated positive skewness and positive kurtosis, suggesting the sample of youth endorsed fewer than expected items and youth ratings were more similar than would be expected in a normal distribution. Again, however, although the data demonstrated non-normality, the current sample is large enough to limit the impact that non-normality could have on statistical tests (Stevens, 2012). Means, standard deviations, skewness, and kurtosis values for parent- and child-report data are presented in Table 6 and Table 7, respectively.

Table 6

Descriptive Statistics for Parent-Report Variables

	N	Mean	SD	Skewness	SE	Kurtosis	SE
Child Age	84	11.86	1.24	0.24	0.26	-0.60	0.52
Parent Depressive Symptoms	84	6.64	7.12	1.74	0.26	3.15	0.52
Parent-Report Parental Acceptance	82	4.18	0.63	-0.32	0.27	-0.90	0.53
Parent-Report Harsh Parenting	82	2.00	0.72	0.82	0.27	0.32	0.53
Parent-Report Baseline Anxious/Depressed	82	3.70	3.30	1.01	0.27	0.32	0.53
Parent-Report Baseline Withdrawn/Depressed	82	2.54	2.46	1.09	0.27	1.01	0.53
Parent-Report Baseline Internalizing Problems	82	7.90	6.70	1.09	0.27	0.982	0.53
Parent-Report Outcome Anxious/Depressed	78	2.60	2.35	0.86	0.27	-0.13	0.54
Parent-Report Outcome Withdrawn/Depressed	78	2.18	2.09	0.81	0.27	-0.23	0.54
Parent-Report Outcome Internalizing Problems	78	6.35	5.04	0.7	0.27	0.03	0.54
Parent-Report Primary Control Youth Coping	82	0.21	0.04	0.65	0.27	0.09	0.53
Parent-Report Secondary Control Youth Coping	82	0.25	0.04	0.74	0.27	-0.03	0.53
Parent-Report Disengagement Youth Coping	82	0.15	0.02	-0.35	0.27	-0.12	0.53
Parent-Report Primary Control Coping Suggestions	82	4.09	0.79	-1.04	0.27	1.313	0.53
Parent-Report Secondary Control Coping Suggestions	82	3.91	0.79	-0.82	0.27	1.21	0.53
Parent-Report Disengagement Coping Suggestions	82	3.74	0.83	-0.54	0.27	0.34	0.53

Table 7

Descriptive Statistics for Child-Report Variables

	N	Mean	SD	Skewness	SE	Kurtosis	SE
Child-Report Parental Acceptance	84	3.82	0.83	-0.85	0.26	0.51	0.52
Child-Report Harsh Parenting	84	2.00	0.69	0.73	0.26	0.31	0.52
Child-report Baseline Anxious/Depressed	84	5.95	3.71	1.14	0.26	1.70	0.52
Child-Report Baseline Withdrawn/Depressed	84	4.43	2.33	0.28	0.26	-0.22	0.52
Child-Report Baseline Internalizing Problems	84	14.79	7.50	1.16	0.26	1.65	0.52
Child-Report Outcome Anxious/Depressed	80	4.23	4.33	2.12	0.27	6.09	0.53
Child-Report Outcome Withdrawn/Depressed	80	3.95	2.59	0.79	0.27	0.25	0.53
Child-Report Outcome Internalizing Problems	80	11.03	8.94	2.26	0.27	6.46	0.53
Child-Report Primary Control Youth Coping	84	0.18	0.04	0.58	0.26	0.32	0.52
Child-Report Secondary Control Youth Coping	84	0.26	0.04	0.30	0.26	0.21	0.52
Child-Report Disengagement Youth Coping	84	0.16	0.02	-0.29	0.26	-0.34	0.52
Child-Report Primary Control Coping Suggestions	84	3.62	0.87	-0.67	0.26	0.19	0.52
Child-Report Secondary Control Coping Suggestions	84	3.54	0.82	-0.47	0.26	0.23	0.52
Child-Report Disengagement Coping Suggestions	84	3.44	0.78	-0.13	0.26	-0.32	0.52

Pearson correlations were run between all study variables and all controls except gender in order to determine which control variables should be included within path models. Differences between parent- and child-report data were examined. Only a small number of correlations between variables of interest and controls were significant for both the parent- and child-report data. Specifically, all baseline measures of youth depressive symptoms were significantly positively correlated with their respective outcome measure of youth depressive symptoms for

both parent- and child-report. In addition, Baseline Internalizing Problems was significantly negatively correlated with Secondary Control Youth Coping for both parent-report (r = -0.26, p = .02) and child-report (r = -.29, p = .01). Parent Depressive Symptoms, Harsh Parenting, and all three baseline measures of youth depressive symptoms had several significant correlations with parent-report variables, but none were shared with child-report. No significant correlations were found with child age for either parent- or child-report data. Given this, it was determined that child age should be omitted from path analyses. Full results of Pearson correlations between study variables and control variables are presented in Table 8 and Table 9.

Independent t-tests were conducted to investigate possible gender differences among all study variables. Significant gender differences between boys and girls appeared only for child-report of Primary Control Youth Coping. Girls (M = 0.19, SD = 0.04) self-reported significantly higher levels Primary Control Youth Coping than boys (M = 0.17, SD = 0.03); t(81)= -2.34, p = .02. No other variables demonstrated significant gender differences.

Table 8

Correlations Between Control Variables and Parent-Report Variables

	Child Age	Parent Depressive Symptoms	Parent-Report Harsh Parenting	Parent-Report Baseline Anxious/ Depressed	Parent-Report Baseline Withdrawn/ Depressed	Parent-Report Baseline Internalizing Problems
Parent-Report Parental Acceptance	-0.07	-0.34**	-0.37**	-0.26*	-0.22	-0.29**
Parent-Report Primary Control Coping Suggestions	-0.08	-0.15	-0.18	-0.13	-0.23*	-0.21
Parent-Report Secondary Control Coping Suggestions	0.0	-0.13	-0.09	-0.18	-0.22*	-0.25*
Parent-Report Disengagement Coping Suggestions	0.10	-0.04	0.03	-0.13	-0.13	-0.17
Parent-Report Primary Control Youth Coping	-0.18	-0.18	-0.27*	-0.13	-0.25*	-0.21
Parent-Report Secondary Control Youth Coping	-0.05	-0.16	-0.34**	-0.28*	-0.09	-0.26*
Parent-Report Disengagement Youth Coping	0.0	0.14	0.15	0.13	0.11	0.11
Parent-Report Outcome Anxious/ Depressed	-0.10	0.37**	0.24*	0.49**	0.33**	0.49**
Parent-Report Outcome Withdrawn/ Depressed	0.19	.0.18	0.20	0.21	0.51**	0.37**
Parent-Report Outcome Internalizing Problems	0.06	0.36**	0.29*	0.44**	0.46**	0.56**

* $p<.05$, ** $p<.01$, *** $p<.001$

Table 9

Correlations Between Control Variables and Child-Report Variables

	Child Age	Parent Depressive Symptoms	Child-Report Harsh Parenting	Child-Report Baseline Anxious/ Depressed	Child-Report Baseline Withdrawn/ Depressed	Child-Report Baseline Internalizing Problems
Child-Report Parental Acceptance	-0.12	0.04	-0.18	0.04	-0.25*	-0.07
Child-Report Primary Control Coping Suggestions	-0.10	-0.06	0.04	0.07	-0.14	0.01
Child-Report Secondary Control Coping Suggestions	-0.15	-0.03	0.04	0.02	-0.17	0.01
Child-Report Disengagement Coping Suggestions	-0.09	0.01	0.12	0.06	-0.11	0.03
Child-Report Primary Control Youth Coping	0.12	-0.14	-0.15	-0.12	-0.17	-0.18
Child-Report Secondary Control Youth Coping	0.07	-0.06	-0.09	-0.20	-0.19	-0.29**
Child-Report Disengagement Youth Coping	0.03	0.22*	0.15	0.14	0.28**	0.24*
Child-Report Outcome Anxious/ Depressed	-0.18	0.03	0.05	0.58**	0.45**	0.60**
Child-Report Outcome Withdrawn/ Depressed	-0.07	0.0	-0.01	0.38**	0.50**	0.41**
Child-Report Outcome Internalizing Problems	-0.22	0.04	0.02	0.55**	0.49**	0.62**

* $p<.05$, ** $p<.01$, *** $p<.001$

Correlations were also run between parent- and child-report for each variable as a cursory inspection of similarities across informants. Parent- and child-report on the Baseline Anxious/Depressed and Internalizing Problems scales were significantly positively correlated at the .05 alpha level, but parent- and child-report on the Baseline Withdrawn/Depressed scale were

not (r = .064, p = .566), with youth reporting a higher mean score. However, parent- and child-report on all three ASEBA scales were significantly correlated at the .01 alpha level at one-year follow up, including for the Withdrawn/Depressed scale (r = .306, p = .006). Interestingly, parent- and child-report of Parental Acceptance were not significantly correlated (r = .195, p = .079), but parent- and child-report of Harsh Parenting was significantly positively correlated (r = .353, p = .001). Parent- and child-report of all three types of Coping Suggestions were significantly positively correlated, but none of the three types of Youth Coping were significantly correlated.

Correlation Analyses

As the next step towards answering the research questions, Pearson correlations between variables of interest were run. Since these were preliminary analyses and not hypothesis testing, analyses were not adjusted to account for multiple comparisons, and p-values were reported at multiple levels of significance. Parent- and child-report data was examined separately, and there were several differences in significant correlations for the parent- and child-report data. Correlations that were significant for both parent- and child-report data are summarized below. Full results of parent-report variables are presented in Table 10 and full results of child-report variables are presented in Table 11.

Table 10

Correlations Between Parent-Report Study Variables

	Parent-Report Parental Acceptance	Parent-Report Primary Control Coping Suggestions	Parent-Report Secondary Control Coping Suggestions	Parent-Report Disengagement Coping Suggestions	Parent-Report Primary Control Youth Coping	Parent-Report Secondary Control Youth Coping	Parent-Report Disengagement Youth Coping	Parent-Report Outcome Anxious/ Depressed	Parent-Report Outcome Withdrawn/ Depressed	Parent-Report Outcome Internalizing Problems
Parent-Report Parental Acceptance	1									
Parent-Report Primary Control Coping Suggestions	0.65**	1								
Parent-Report Secondary Control Coping Suggestions	0.55**	0.82**	1							
Parent-Report Disengagement Coping Suggestions	0.36**	0.61**	0.85**	1						
Parent-Report Primary Control Youth Coping	0.20	0.32**	0.24*	0.19	1					
Parent-Report Secondary Control Youth Coping	0.33**	0.24*	0.27*	0.16	0.37**	1				
Parent-Report Disengagement Youth Coping	-0.24*	-0.2	-0.14	-0.07	-0.50**	-0.33**	1			
Parent-Report Outcome Anxious/Depressed	-0.23*	-0.19	-0.23*	-0.21	-0.21*	-0.30**	0.09	1		
Parent-Report Outcome Withdrawn/Depressed	-0.31**	-0.44**	-0.38**	-0.32**	-0.42**	-0.33**	0.12	0.52**	1	
Parent-Report Outcome Internalizing Problems	-0.26*	-0.25*	-0.25*	-0.20	-0.33**	-0.39**	0.12	0.84**	0.79**	1

* $p<.05$, ** $p<.01$, *** $p<.001$

Table 11

Correlations Between Child-Report Study Variables

	Child-Report Parental Acceptance	Child-Report Primary Control Coping Suggestions	Child-Report Secondary Control Coping Suggestions	Child-Report Disengagement Coping Suggestions	Child-Report Primary Control Youth Coping	Child-Report Secondary Control Youth Coping	Child-Report Disengagement Youth Coping	Child-Report Outcome Anxious/ Depressed	Child-Report Outcome Withdrawn/ Depressed	Child-Report Outcome Internalizing Problems
Child-Report Parental Acceptance	1									
Child-Report Primary Control Coping Suggestions	0.64**	1								
Child-Report Secondary Control Coping Suggestions	0.61**	0.80**	1							
Child-Report Disengagement Coping Suggestions	0.48**	0.76**	0.81**	1						
Child-Report Primary Control Youth Coping	0.32**	0.28*	0.13	0.14	1					
Child-Report Secondary Control Youth Coping	0.31**	0.19	0.24*	0.14	0.13	1				
Child-Report Disengagement Youth Coping	-0.37**	-0.37**	-0.32**	-0.16	-0.35**	-0.27**	1			
Child-Report Outcome Anxious/ Depressed	-0.12	0.03	-0.12	-0.09	-0.23*	-0.26**	0.16	1		
Child-Report Outcome Withdrawn/ Depressed	-0.29**	-0.10	-0.22*	-0.18	-0.17	-0.17	0.19	0.75**	1	
Child-Report Outcome Internalizing Problems	-0.16	0.03	-0.08	-0.08	-0.21*	-0.27**	0.12	0.94**	0.84**	1

* $p<.05$, ** $p<.01$, *** $p<.001$

Parental Acceptance & Youth Coping

Parental Acceptance was significantly positively correlated with Secondary Control Youth Coping for both parent-report (r = .342, p = .002) and child-report (r = .271, p = .014). Parental Acceptance was also significantly negatively correlated with Disengagement Youth Coping for parent-report (r = -.254, p = .021) and child-report (r = -.325, p = .003). The relationship between Parental Acceptance and Primary Control Youth Coping was significant for child-report but not parent-report.

Parental Acceptance & Parent Coping Suggestions

Parental Acceptance was significantly positively correlated with all three types of Coping Suggestions for both parent- and child-report. Specifically, Parental Acceptance was significantly positively correlated with Primary Control Coping Suggestions (r = .653, p < .001 and r = .608, p < .001), Secondary Control Coping Suggestions (r = .550, p < .001 and r = .573, p < .001). It was also significantly positively correlated with Disengagement Coping Suggestions (r = .364, p = .001 and r = .450, p < .001), for parent- and child-report respectively.

Parent Coping Suggestions & Youth Coping

Among the nine sets of correlation analyses run between these variables, only Primary Control Coping Suggestions was significantly correlated with Primary Control Youth Coping for both parent-report (r = .317, p = .004) and child-report (r = .273, p = .013). Primary Control Coping Suggestions and Secondary Control Coping Suggestions did not have any consistently significant relationships across parent- and child-report with any of the Youth Coping variables. Disengagement Coping Suggestions was not significantly correlated with any Youth Coping variables for either parent- or child-report.

Youth Coping & Outcome Youth Depressive Symptoms

Secondary Control Youth Coping was significantly negatively correlated with all outcome measures of youth depressive symptoms for both parent- and child-report. Specifically, Secondary Control Youth Coping was significantly correlated with Outcome Anxious/Depressed (r = -.269, p = .017 and r = -.344, p = .002), Outcome Withdrawn/Depressed (r = -.248, p = .029 and r = -.242, p = .033), and Outcome Internalizing Problems (r = -.319, p = .004 and r = -.359, p =.001) for both parent- and child-report, respectively. Relationships between Primary Control Youth Coping and outcome youth depressive symptoms were not consistently significant across parent- and child-report. Disengagement Youth Coping was not significantly correlated with any outcome measure of youth depressive symptoms for either parent- or child-report.

Parent Coping Suggestions & Outcome Youth Depressive Symptoms

No relationships between Coping Suggestions variables and measures of outcome youth depressive symptoms were consistently significant across both parent- and child-report. Many correlations were significant in the parent-report data, but none were significant in the child-report data. Within the parent-report data, all three types of Coping Suggestions (including Disengagement Coping Suggestions) had negative correlations with outcome youth depressive symptoms.

Parental Acceptance & Outcome Youth Depressive Symptoms

Parental Acceptance was significantly negatively correlated with Outcome Withdrawn/Depressed for both parent-report (r = -.310, p = .006) and child-report (r = -.262, p = .020). Correlations with Outcome Anxious/Depressed and Outcome Internalizing Problems were significant for parent-report but not child-report data.

Path Analysis

The statistical modeling software *MPlus* Version 7 (Muthén & Muthén, 2012) was used to examine the hypothesized relationships between the four groups of variables of interest (Parental Acceptance, Coping Suggestions, Youth Coping, and Outcome Youth Depressive Symptoms) and the four selected control variables (child gender, Parent Depressive Symptoms, Harsh Parenting, and Baseline Youth Depressive Symptoms). If paths from all proposed control variables to all study variables were included in the model, the model would be considered "just-identified", which would not allow for indices of model fit to be interpreted (Kenny, 2011). Therefore, at least one path had to be removed in order for the model to be over-identified and allow the fit of the proposed model to be evaluated. The path between child gender and Parental Acceptance was selected to be removed from the proposed models based on the following: (a) child gender was the only control variable found to be significantly correlated with only one study variable (child-report of Primary Control Youth Coping), (b) the relationship between child gender and Parental Acceptance is not central to the research questions and has been demonstrated to be inconsistent in the extant literature (Endendijk et al., 2016; Varela, et al., 2004) (c) Parental Acceptance is the only study variable in the model that does not have multiple domains so removing this path truly only removes one path, and (d) Youth Coping and Coping Suggestions variables are the most novel pieces of the model, so all control paths to these variables should ideally be maintained.

As previously explained, nine parent-report models and nine child-report models were run for each of three of selected ASEBA scales that tap into youth depressive symptoms, resulting in a total of 54 models. For both the parent- and child-report models, those that used the Withdrawn/Depressed scale had many more significant paths than those that used the

Anxious/Depressed or Internalizing Problems scales. Models that used the Anxious/Depressed and Internalizing Problems scales shared nearly all of the same significant paths, with models that used the Anxious/Depressed scale having a couple more significant paths than those that used the Internalizing Problems scale in both the parent- and child-report models.

Given (a) the similarity between how the Anxious/Depressed and Internalizing Problems scales performed in the models, (b) the previously described evidence that the Anxious/Depressed scale has better empirical specificity with youth depressive symptoms than the Internalizing Problems scale (Achenbach, Rescorla, & Maruish, 2004), and (c) the Internalizing Problems scale is a composite of the Withdrawn/Depressed and Anxious/Depressed items, this dissertation will focus on results of models that used the Withdrawn/Depressed and Anxious/Depressed scales.

Model fit

Model fit for both parent- and child-report data was assessed using the Chi-square (x^2) test of conceptual and baseline model fit, the comparative fit index (CFI), the Tucker-Lewis Index (TLI), Standardized Root Mean Square Residual (SRMR), and the Root Mean Squared Error of Approximation (RMSEA). Results indicated that all models fit the data well. For both the parent- and child-report data, all Chi-square tests for the conceptual model fit were non-significant and all Chi-square tests of baseline model fit were significant, indicating the conceptual model fit the data well. All CFI and TLI values were greater than or equal to .90, indicating good model fit. All SRMR values were less than .05, indicating good model fit. All RMSEA estimates were less than .05, indicating good model fit. Results for all 36 models that used the Withdrawn/Depressed and Anxious/Depressed scales are summarized below and

grouped by informant and ASEBA measure used. Each row in the table summarizes results for the nine path models that utilized the given ASEBA scale.

Table 12

Model Fit Indices

Models	Conceptual model x^2	df	Baseline x^2 range	df	CFI	TLI range	SRMR range	RMSEA (90% CI)
Parent-Report Withdrawn/Depressed	.503	1	76.677*** - 126.703***	22	1	1.104 - 1.173	.012 - .013	0 (0 - .259)
Parent-Report Anxious/Depressed	.651	1	70.726*** - 112.977***	22	1	1.084 – 1.157	.013 - .015	0 (0 - .270)
Child-Report Withdrawn/Depressed	1.096	1	77.207*** - 122.383***	22	.999	.962 - .979	.018 - .022	.034 (0 - .294)
Child-Report Anxious/Depressed	.104	1	85.165*** - 123.444***	22	1	1.194 – 1.312	.006 - .007	0 (0 - .200)

Note. Each row summarizes results of nine models utilizing the given ASEBA scale.

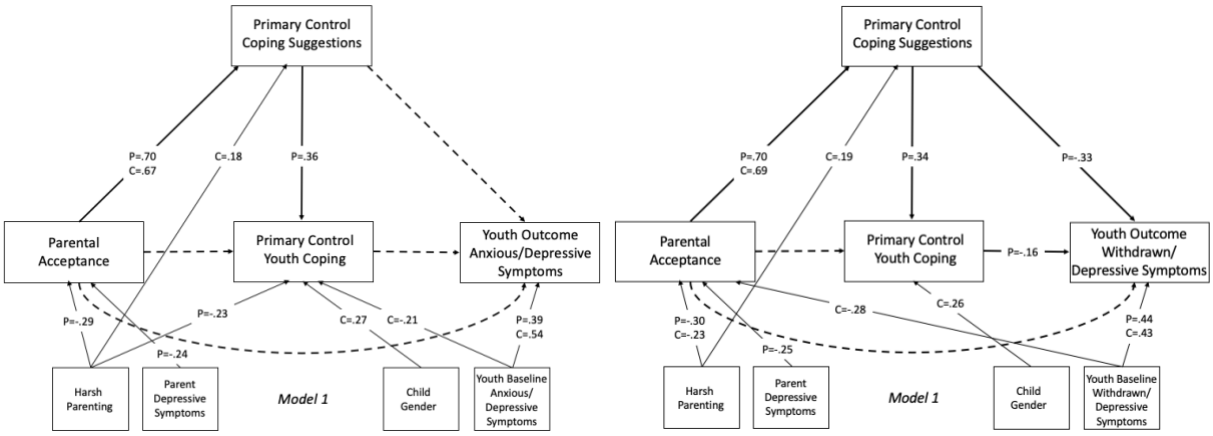
* $p<.05$, ** $p<.01$, *** $p<.001$

The results of path analyses are summarized below and organized by research question. Statistically significant paths are also presented in Figures 7-15. In order to facilitate comparisons, results from analyses using the Anxious/Depressed and Withdrawn/Depressed scales are presented as separate figures side-by-side for each model, and each figure contains results from both the parent- and child-report data. Statistically significant relationships ($p<.05$) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows. Direct paths that are statistically significant, adjoining, and pointing in the same direction also represent statistically significant mediation paths in the figures. For visual simplicity, only standardized values, statistically significant paths, and nonsignificant paths central to hypotheses are included in the models – unstandardized values, values for nonsignificant paths, and nonsignificant paths with control variables are omitted. Full results of direct path analyses (both standardized and unstandardized values, standard errors, and *p* values) are presented in Appendix

H and I for the parent-report data and Appendix J and K for the child-report data. Full results of indirect path analyses are presented in Appendix L and M for the parent-report data and Appendix N and O for the child-report data. It should be noted that in keeping with hypotheses and the terminology used in path analysis, results will summarize variables that significantly "predicted" others. However, as previously described, Parental Acceptance, Harsh Parenting, Coping Suggestions, and Youth Coping were all measured at the same time point, so the direction of the relationships between these variables is unknown.

Figure 7

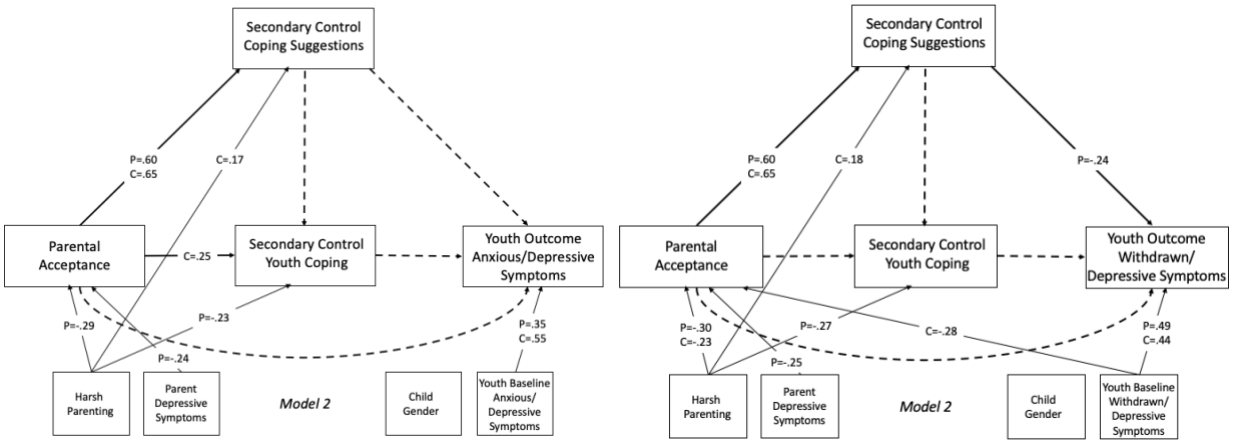
Model 1



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 8

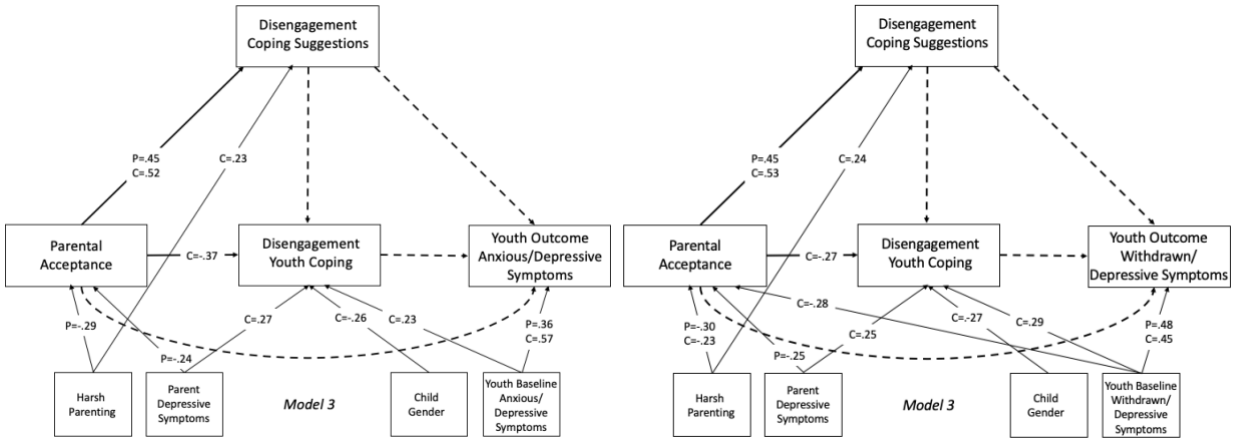
Model 2



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 9

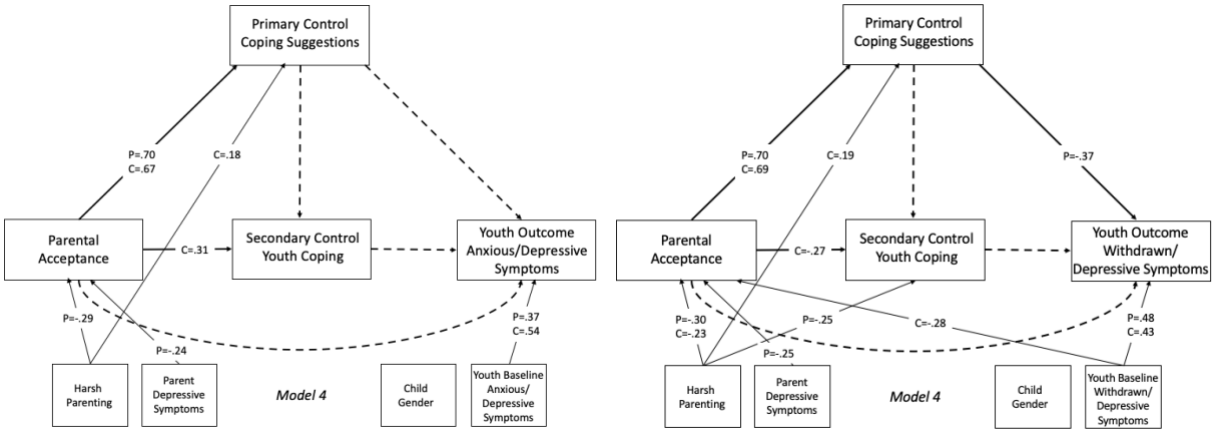
Model 3



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 10

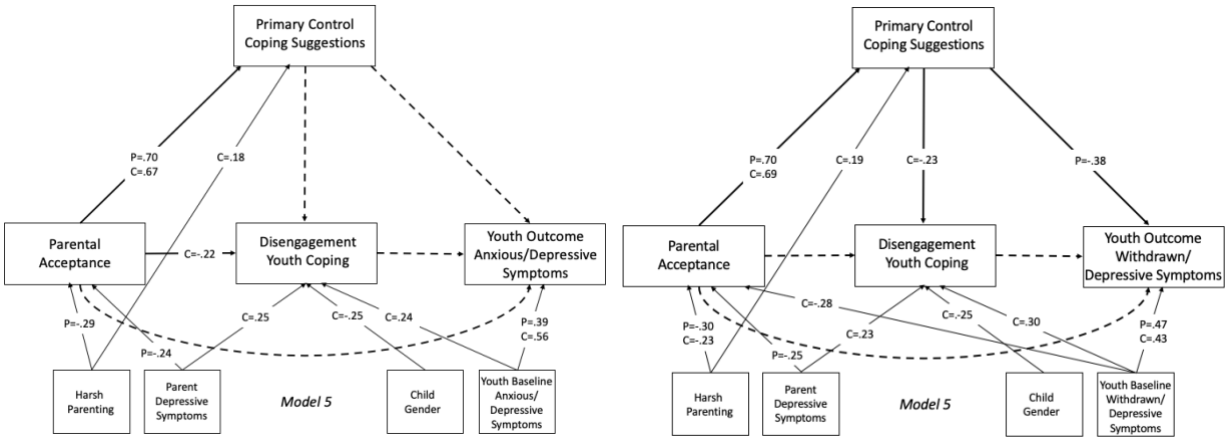
Model 4



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 11

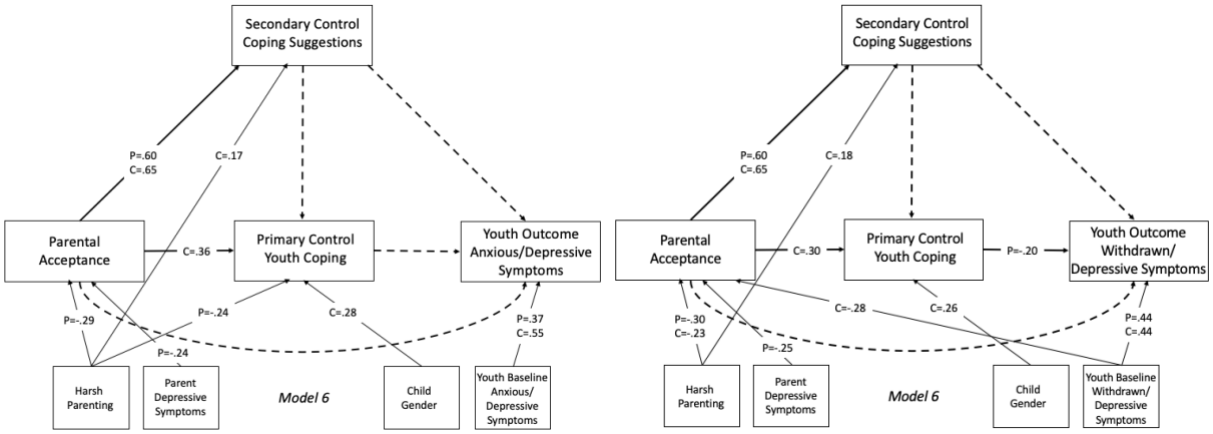
Model 5



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 12

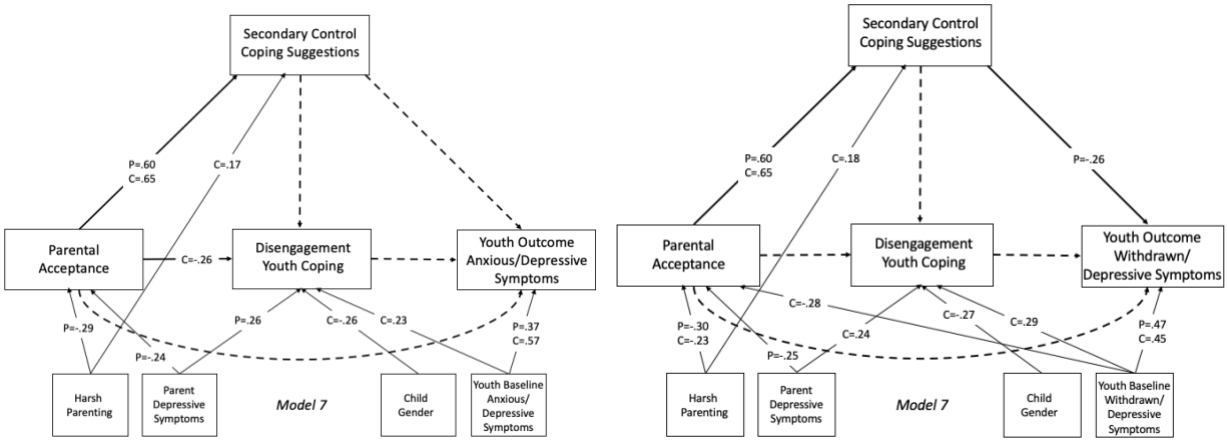
Model 6



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 13

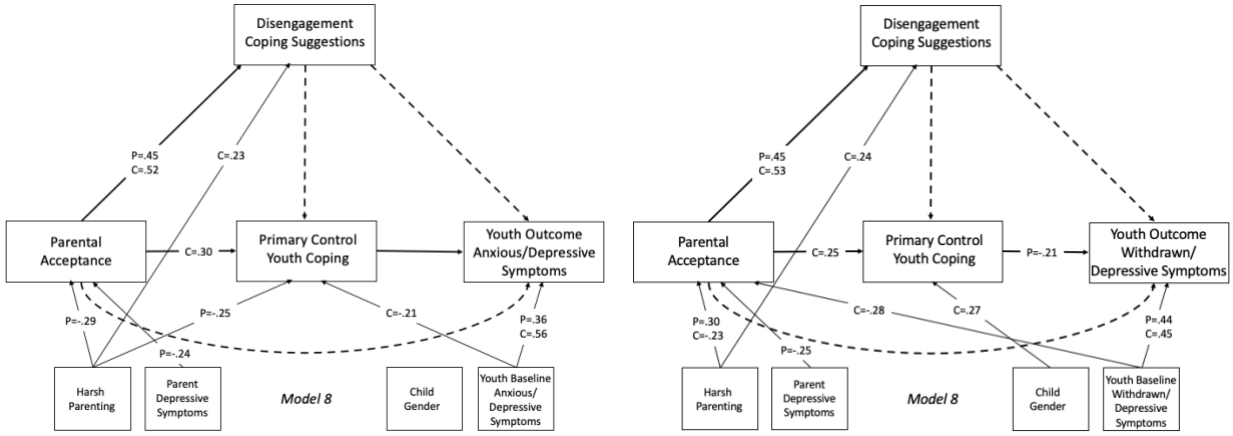
Model 7



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 14

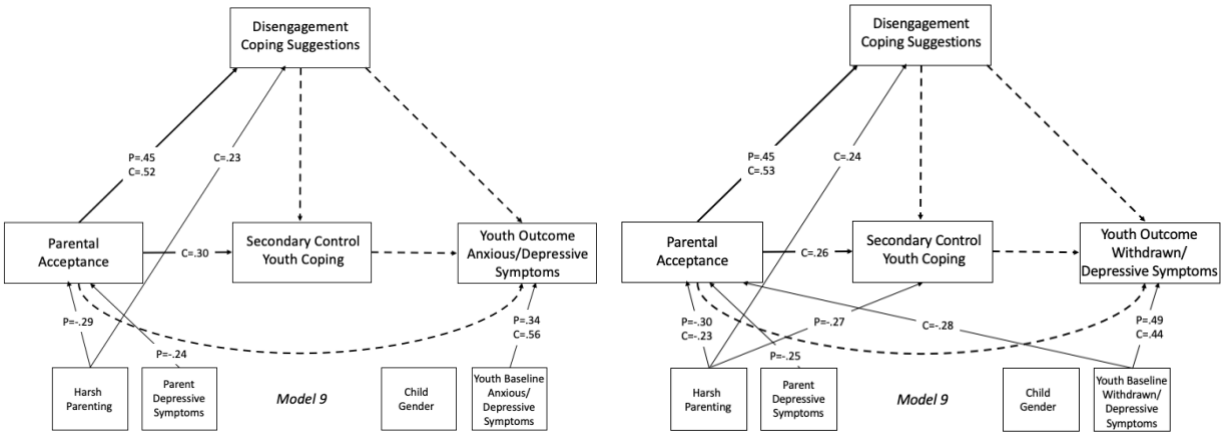
Model 8



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Figure 15

Model 9



Note: Statistically significant relationships (p<.05) are symbolized with solid arrows and nonsignificant relationships are represented with dashed arrows.

Hypothesis 1: Parental acceptance will positively predict primary and secondary control youth coping and negatively predict disengagement youth coping.

Parent models. Contrary to what was expected, Parental Acceptance never significantly predicted any Youth Coping variable in any parent-report models using either the Withdrawn/Depressed or Anxious/Depressed scale.

Child models. In accordance with hypotheses, Parental Acceptance significantly predicted Primary Control Youth Coping (positively), Secondary Control Youth Coping (positively), and Disengagement Youth Coping (negatively) in most child-report models using both the Withdrawn/Depressed scale and Anxious/Depressed scale.

Hypothesis 2: a) Primary control coping suggestions will mediate the relationship between parental acceptance and primary control youth coping, b) Secondary control coping suggestions will mediate the relationship between parental acceptance and secondary control youth coping, and c) Disengagement coping suggestions will mediate the relationship between parental acceptance and disengagement youth coping.

Parent models. For the parent-report data, of the nine possible combinations of Coping Suggestions and Youth Coping scales, only one combination resulted in a statistically significant indirect effect: Primary Control Coping Suggestions positively mediated the relationship between Parental Acceptance and Primary Control Youth Coping. This effect was significant for parent-report models using both the Withdrawn/Depressed and Anxious/Depressed scales.

For the direct paths within this indirect path, of the nine possible combinations of Coping Suggestions and Youth Coping, only one combination resulted in a statistically significant direct effect: Primary Control Coping Suggestions significantly positively predicted Primary Control Youth Coping. Again, this effect was significant for both the Withdrawn/Depressed and Anxious/Depressed parent-report models. For the second direct path, Parental Acceptance was found to significantly positively predict all three types of Coping Suggestions, even

Disengagement Coping Suggestions. This path was significant in every Withdrawn/Depressed and Anxious/Depressed parent-report model and was the most consistently significant direct effect across all path analyses.

Child models. For the child-report data, Coping Suggestions never significantly mediated the relationship between Parental Acceptance and Youth Coping in models using either the Withdrawn/Depressed or Anxious/Depressed scale.

In terms of direct effects in the child models, a different single combination of Youth Coping and Coping Suggestions resulted in a statistically significant direct effect: Primary Control Coping Suggestions significantly negatively predicted Disengagement Youth Coping in models using the Withdrawn/Depressed scale, but never in models using the Anxious/Depressed scale. For the second direct path, similar to the parent models, Parental Acceptance significantly positively predicted every type of Coping Suggestion – even Disengagement Coping Suggestions – in every child-report model.

Hypothesis 3: Primary and secondary control youth coping will negatively predict youth depressive symptoms, and disengagement youth coping will positively predict youth depressive symptoms.

Parent models. For the parent-report data, Primary Control Youth Coping significantly negatively predicted Outcome Withdrawn/Depressed, but neither Secondary Control Youth Coping nor Disengagement Youth Coping significantly predicted Outcome Withdrawn/Depressed. No type of Coping Suggestion significantly predicted Outcome Anxious/Depressed in the parent-report models.

Child models. Contrary to what was expected, no type of Youth Coping significantly predicted Outcome Withdrawn/Depressed or Outcome Anxious/Depressed in the child-report models.

Hypothesis 4: Primary and secondary control coping suggestions will negatively predict youth depressive symptoms, and disengagement coping suggestions will positively predict youth depressive symptoms.

Parent models. For the parent-report data, both Primary Control Coping Suggestions and Secondary Control Coping Suggestions significantly negatively predicted Outcome Withdrawn/Depressed in most models, but Disengagement Coping Suggestions did not significantly predict Outcome Withdrawn/Depressed. No type of Coping Suggestion significantly predicted Anxious/Depressed for the parent-report models.

Child models. Contrary to what was expected, no type of Coping Suggestion significantly predicted Outcome Withdrawn/Depressed or Outcome Anxious/Depressed in the child-report models.

Hypothesis 5: Parental acceptance will negatively predict youth depressive symptoms.

Parent models. Contrary to what was expected, Parental Acceptance never significantly predicted Outcome Withdrawn/Depressed or Outcome Anxious/Depressed in the parent-report models.

Child models. Just like the parent-report models, Parental Acceptance never significantly predicted Outcome Withdrawn/Depressed or Outcome Anxious/Depressed in the child-report models.

Control Paths

Though not directly addressing research questions, direct effects between control variables and main study variables were also examined in path analyses and are summarized below. Full results of direct path analyses are summarized in tables in Appendix H and I for the parent-report data and Appendix J and K for the child-report data.

Harsh Parenting. Harsh Parenting significantly negatively predicted Parental Acceptance in every parent-report model using both Withdrawn/Depressed and Anxious/Depressed scales. However, Harsh Parenting only significantly negatively predicted Parental Acceptance in child-report models using Withdrawn/Depressed, but never in models using Anxious/Depressed. In addition, Harsh Parenting significantly negatively predicted Primary Control Youth Coping in parent-report models using Anxious/Depressed (but not when using Withdrawn/Depressed), and negatively predicted Secondary Control Youth Coping in most parent-report models using both Withdrawn/Depressed and Anxious/Depressed scales. Harsh Parenting never predicted Disengagement Youth Coping in the parent-report models, and never predicted any type of Youth Coping in the child-report models. Harsh Parenting significantly positively predicted all three types of Coping Suggestions in all child models using both Withdrawn/Depressed and Anxious/Depressed scales, but was never significant in parent-report models. For both the parent- and child-report data, Harsh Parenting never predicted Outcome Withdrawn/Depressed or Outcome Anxious/Depressed.

Child Gender. Child gender did not significantly predict any parent-report variables. However, child gender did significantly predict child-report of Primary Control Youth Coping and Disengagement Youth Coping in models using both Withdrawn/Depressed and Anxious/Depressed scales, with girls endorsing more Primary Control Youth Coping than boys,

and boys endorsing more Disengagement Youth Coping than girls. Child gender did not significantly predict child-report of Secondary Control Youth Coping, any Coping Suggestions, Outcome Withdrawn/Depressed, or Outcome Anxious/Depressed.

Parent Depressive Symptoms. Parent Depressive Symptoms significantly negatively predicted Parental Acceptance in all parent-report models, but was never significant in child-report models. Parent Depressive Symptoms also positively predicted child-report of Disengagement Youth Coping in models using both Withdrawn/Depressed and Anxious/Depressed, but never predicted child-report of Primary or Secondary Control Coping or parent-report of any Youth Coping variables. Parent Depressive Symptoms never predicted Outcome Withdrawn/Depressed, Outcome Anxious/Depressed, or any type of Coping Suggestion in either parent- or child-report models.

Baseline Youth Depressive Symptoms. As expected, both baseline measures of youth depressive symptoms significantly positively predicted their respective outcome measure of youth depressive symptoms in all parent- and child-report models. However, parent-report of baseline youth depressive symptoms never predicted any other parent-reported variable. For the child-report models, Baseline Withdrawn/Depressed (but not Baseline Anxious/Depressed) significantly negatively predicted Parental Acceptance. Both Baseline Withdrawn/Depressed and Baseline Anxious/Depressed significantly positively predicted Disengagement Youth Coping in all child-report models. Baseline Anxious/Depressed (but not Baseline Withdrawn/Depressed) significantly negatively predicted Primary Control Youth Coping in most child-report models, but neither ever significantly predicted Secondary Control Youth Coping. Baseline youth depressive symptoms never predicted any type of Coping Suggestion in parent- or child-report models.

Other Mediation Paths

Three indirect effects that were not central to hypotheses but part of the proposed models were also examined in path analyses to assess the validity of the theoretical model. Full results of indirect path analyses are presented in Appendix L and M for the parent-report data and Appendix N and O for the child-report data. First, all three types of Coping Suggestions were found to significantly negatively mediate the relationship between Parental Acceptance and Withdrawn/Depressed in parent-report models. However, this relationship was not significant in parent-report models using Anxious/Depressed or in any child-report models.

Second, contrary to what was expected, Youth Coping never mediated the relationship between Parental Acceptance and outcome youth depressive symptoms in any parent- or child-report model.

Lastly, the four-variable indirect effect from Parental Acceptance to Coping Suggestions, Youth Coping, and outcome youth depressive symptoms was examined. This mediating relationship was only significant for one parent model: Primary Control Coping Suggestions and Primary Control Youth Coping negatively mediated the relationship between Parental Acceptance and Withdrawn/Depressed. This relationship was never significant in parent-report models using Anxious/Depressed or in any child-report models.

Chapter 4: Discussion

The purpose of the present study was to examine the relationships among parenting, parent coping suggestions, youth coping with family conflict, and depressive symptoms in early adolescent youth in Latinx families. A longitudinal design was utilized, and data were analyzed using path analysis. Models of parent-report and child-report data were analyzed separately, and separate models were run for each of the ASEBA subscales measuring depressive symptoms. Overall, there was partial support for hypotheses, and more significant results emerged in the parent-report than child-report data.

The characteristics of the sample are important to consider when interpreting results of the study. Previous research has identified early and middle adolescence as the key period for understanding how coping predicts the development of depressive symptoms in youth (Compas et al., 2017), and the prevalence of depressive symptoms has been found to particularly increase between the ages of 13 and 18 years (Kessler et al., 2005). Youth in the present sample were 10 to 15 years of age, but the mean age was just under 12 years old and the modal age was 11. The age of this sample might have impacted findings in several ways. First, it is likely the young age of the sample at least partially explains the relatively low rates of clinically elevated depressive symptoms that were observed.

Second, the age of the sample could explain the surprising absence of gender differences in depressive symptoms. Previous research suggests that girls only exhibit significantly greater depressive symptoms than boys around 14 years of age (Wade, Cairney, & Pevalin, 2002), which is older than the majority of the present sample.

Third, the narrow range in age in the sample likely explains the absence of significant correlations between study variables and child age. No significant correlations were found

between child age and parent- or child-report of any variables, which led to age being omitted from path analyses.

Fourth, the young age of the sample might also explain the lack of correlations between secondary control youth coping and youth depressive symptoms. Secondary control coping skills – especially cognitive types – have been found to develop later than behavioral and primary control coping skills (Skinner & Zimmer-Gembeck, 2010). Age has also previously been found to moderate the association between coping and internalizing symptoms, such that a negative association between engagement coping and internalizing symptoms has been found for adolescents but not for children (Compas et al., 2017). It is possible that due to the young age of this sample, these youth did not have well-developed secondary control coping skills, which is why parent- and child-report of these skills did not protect against depressive symptoms. It is also possible that secondary control coping with family conflict is protective against depressive symptoms for older Latinx adolescents even though it did not appear to be protective for this younger sample.

Several additional characteristics of the sample might have contributed to the low rates of depressive symptoms observed. Prior research has estimated that 15% of Latinx adolescents experienced clinical depression in the previous year (McCance-Katz, 2018), and 22% of Latinx youth ages 11 to 15 years old experienced subclinical depressive symptoms (Saluja et al., 2004). In comparison, only 11.25% of youth in the present study reported clinically elevated symptoms on the Internalizing Problems scale, and less than 10% of youth and parents reported clinically elevated symptoms on the Withdrawn/Depressed and Anxious/Depressed scales. These low rates of depressive symptoms likely partially explain why many of the hypothesized paths were not significant in the present study. In addition to the young age of the sample, participating youth

might be more bicultural than the general population of Latinx youth. Youth in the present study were required to have at least minimal competence in both Spanish and English as reported by their parents. Bilingualism is a component of bicultural identity (Bacallao & Smokowski, 2009), and both bilingualism and biculturalism have been found to protect against mental health problems in youth, including internalizing and depressive symptoms (Bacallao & Smokowski, 2009; Miranda & Umhoefer, 1998). Lastly, these youth might have benefited from the "immigrant paradox". Research has found that both within individuals and across generations, recent immigrants are healthier (both physically and mentally) than those who have been in the United States for longer (Bowe, 2017; Marks, Ejesi, & García Coll, 2014). Since over 90% of parents in the sample reported immigrating to the U.S., this could partially explain the relatively low incidence of depressive symptoms in the sample of predominantly 2nd generation youth. A higher incidence of depressive symptoms might have been observed in an older, less bicultural, and later generation of Latinx youth.

Results relevant to each hypothesis are summarized below. Methodological limitations, strengths of the study, and future research and clinical implications are discussed at the end of the document.

Research Question 1

The first research question of this study aimed to determine whether parental acceptance was associated with youth coping in the context of family conflict. As hypothesized, in most of the models using child-report data, child-report of parental acceptance was significantly positively correlated with primary control and secondary control youth coping, and negatively correlated with disengagement youth coping. Since the RSQ measure of coping is scored as a proportion score, this means that children who perceived their parents to be especially

warm/accepting reported using more primary and secondary control coping than disengagement coping. This study provides additional evidence of the relationship between parental acceptance and youth coping using evidence-based measures and suggests parental acceptance may support adaptive coping in Latinx youth experiencing family conflict.

However, parental acceptance was not found to be significantly correlated with any youth coping variable in the parent-report data. This conflicts with previous evidence that parent-report of warm/accepting parenting is positively associated with engagement youth coping and negatively associated disengagement coping (Vélez, Wolchik, Tein, & Sandler, 2011; Watson et al., 2014). It should be noted that parent and child responses were not significantly correlated on the parental acceptance measure or for any of the coping subscales. The different results for the parent- and child-report data are surprising because the RSQ is one of the few measures of coping that has demonstrated significant cross-informant correlations (Compas et al., 2017). However, these differences in the parent- and child-report data are not entirely surprising given the extensive evidence of informant discrepancies on social-emotional questionnaires (e.g., Achenbach, McConaughy, & Howell, 1987). In addition, there is some prior evidence of discrepancies between parent- and child-report on the RSQ (Jaser et al., 2005). These findings suggest that this population of parents and children might have different perceptions of parental acceptance and/or youth coping in the context of family conflict.

Research Question 2

The second research question aimed to examine whether parent coping suggestions mediate the relationship between parental acceptance and youth coping. This relationship was only significant in the parent-report data once for both the Withdrawn/Depressed & Anxious/Depressed models: primary control coping suggestions positively mediated the

relationship between parental acceptance and primary control youth coping. This mediation relationship was not significant in any of the child-report models. These results suggest that parents' primary control coping suggestions – but not secondary control or disengagement coping suggestions – mediate the relationship between parental acceptance and youth coping with family conflict for Latinx youth. This finding sheds light on one possible reason parental acceptance is relevant to youth coping: when parents show warmth/acceptance, they also tend to provide primary control suggestions for coping with family conflict, which might lead children to use primary control coping skills. Examination of the direct paths that make up this indirect pathway provide possible explanations for this finding.

For the first direct path in this mediation hypothesis, parental acceptance was found to be positively associated with every type of coping suggestion for both the parent- and child-report data. This path was significant in every parent- and child-report model and was the most consistently significant effect across all path analyses conducted. Unexpectedly, parental acceptance even consistently positively – not negatively – predicted disengagement coping suggestions. These results suggest that parents who are high in acceptance might be more likely to suggest any type of coping than parents who are low in acceptance. In other words, rather than parental acceptance predicting the type of coping suggestions parents make, parental acceptance might predict the quantity of coping suggestions they make overall. This could be because parents who are warm and accepting are more likely to approach and/or be approached by children about coping challenges (Abaied & Rudolph, 2011; Vélez, Wolchik, Tein, & Sandler, 2011; Watson et al., 2013), but their level of warmth/acceptance has no bearing on the type of coping suggestions they make. This might also align with conceptualizations of protective parenting in Latinx families as being high in warmth, high on demandingness, and low on

autonomy granting (Domenech Rodríguez, Donovick, & Crowley, 2009). Perhaps providing coping suggestions is a way parents involve themselves in their children's lives and attempt to protect them.

In regard to the second direct path, parent-report (but not child-report) of primary control coping suggestions were found to be positively correlated with parent-report of primary control youth coping in both the Withdrawn/Depressed & Anxious/Depressed models. This finding suggests that primary control coping suggestions might be more easily transmissible through explicit instruction than secondary control or disengagement coping in the context of family conflict. In contrast to secondary control, primary control coping is conceptually more concrete and likely more easily explained, understood, implemented, and observable than secondary control coping. Children might also find it easier to apply primary control coping suggestions to family conflict, specifically. Given the significant negative correlation between primary control coping with family conflict and child depressive symptoms (which will be later described), it also seems that primary control coping might be a better match to this stressor for this population.

Primary control coping suggestions were also significantly negatively correlated with disengagement youth coping in the child-report data (but not the parent-report data); this relationship was only significant in models using the Withdrawn/Depressed scale. This means children who believe their parents have made primary control coping suggestions report not using as many disengagement coping strategies. This could be because when children receive primary control coping suggestions from parents, they are unable to avoid or disengage from family conflict as easily. This finding partially aligns with prior evidence from Abaied and Rudolph (2011) that mothers' engagement coping suggestions negatively predicted involuntary

disengagement with stressors in youth. These authors theorized that when parents give engagement coping suggestions, they communicate to the child that engaging with the stressor is safe and that the child is capable of managing the stressor (Abaied & Rudolph, 2011). Even if parent primary control coping suggestions do not reliably result in children using primary control coping, these suggestions might at minimum prevent children from completely disengaging with family conflict.

Discrepancies in significant paths across the parent- and child-report models indicate that youth might not perceive the impact of parent coping suggestions on their coping in the same way parents do. Since results using the child self-report version of the SOC have not been previously published, it remains unclear whether children this age can accurately report on parents' coping suggestions. However, significant correlations between parent- and child-report of coping suggestions were found in the present study, though not for youth coping, surprisingly. It is possible that children in this sample were in fact engaging in primary control coping strategies as reported by their parents, but were not aware, perhaps due to their relatively young age.

There are several possible explanations for the lack of correlation between secondary control coping suggestions and youth secondary control coping. First, to the knowledge of this author, a significant correlation between secondary control coping suggestions and youth secondary control coping has not been previously found using the SOC measure (Abaied & Rudolph, 2011). In addition, findings related to the development of coping skills in children suggest that cognitive secondary control coping skills do not emerge until late childhood (Skinner & Zimmer-Gembeck, 2010). Given these children were 10 to 15 years old and the majority were on the lower end of this range, it is possible that these children had more difficulty

implementing parents' secondary control coping suggestions due to their developmental age. It is also important to note that Abaied and Rudolph (2011) found that mothers' coping suggestions only significantly predicted youth coping when peer stress was high. When peer stress was low, mothers' suggestions were not significantly related to youth coping. It is possible that this sample of youth was experiencing a low level of family stress, and this explains the few correlations between parent coping suggestions and youth coping.

Disengagement coping suggestions and disengagement youth coping were also not significantly correlated in this study. This could be because disengagement coping is not as transmissible as engagement coping through coping suggestions. Abaied and Rudolph (2011) found that high levels of disengagement coping suggestions from parents predicted high use of involuntary disengagement in youth, but not disengagement coping. In the context of family conflict, if parents give disengagement coping suggestions to children, parents' behavior inherently conflicts with the complete avoidance of family conflict that would define disengagement coping with family conflict. Therefore, disengagement coping suggestions for family conflict could in fact support children's engagement with family conflict. In addition, multiple prior studies have found that parent variables are not strongly correlated with disengagement coping in youth (Power, 2004).

The few correlations between coping suggestions and youth coping and the many correlations between parental acceptance and all types of coping suggestions could also be due to limitations in the measurement of coping suggestions used in this study. To the knowledge of this author, no research using the child-report version of the Socialization of Coping (SOC) measure has been published, and no published study with the parent-report version has used a Latinx sample. The measure was translated into Spanish for the present study by the bilingual

research team without use of a focus group, which may compromise the validity of the measure. In addition, unlike the RSQ measure of coping, the SOC measure of coping suggestions produces mean scores rather than relative proportion scores for each domain. It therefore remains unclear whether parental acceptance is more likely to predict certain types of coping suggestions over others. Finally, the many correlations between parental acceptance and coping suggestions could indicate that the SOC taps into a parenting construct similar to parental directiveness. This will be further addressed in later in the document.

Research Question 3

The third research question examined whether youth coping with family conflict predicted later youth depressive symptoms. As expected, parent-report of primary control youth coping significantly negatively predicted parent-report of youth depressive symptoms six months later using the Withdrawn/Depressed scale. However, parent-report of neither secondary control youth coping nor disengagement youth coping predicted later Withdrawn/Depressed symptoms, and no type of parent-reported youth coping predicted Anxious/Depressed symptoms.

Results from this study align with prior findings that primary control coping can protect against depressive symptoms in the general population of youth (Bettis et al., 2016; Compas et al., 2017) and against internalizing symptoms in low-SES populations (Santiago & Wadsworth, 2009; Santiago & Wadsworth, 2011). The significant negative correlation between primary control coping and youth depressive symptoms six months later in both boys and girls in this sample suggests that primary control coping with family conflict is protective against depressive symptoms in Latinx youth. The lack of association between secondary control coping and later youth depressive symptoms conflicts with prior evidence that secondary control coping is protective against youth internalizing symptoms (Compas et al., 2017), including in low-SES

families (Santiago & Wadsworth, 2009). Based on Compas et al.'s (2001) control-based model of coping, it is possible family conflict is more within youth's control for low-SES Latinx youth compared to non-Latinx youth. Though prior studies have found that primary control coping only protected against depressive symptoms for girls in non-Latinx samples (Santiago & Wadsworth, 2009), it is possible that emotional expression, a component of primary control coping, is more culturally acceptable for Latinx boys compared to non-Latinx boys (Santiago & Wadsworth, 2009), and could therefore be protective for both genders. Finally, as previously noted, it is possible that the relatively young age of this sample impacted the relationship between coping and depressive symptoms (Compas et al., 2017).

It is important to note that no type of youth coping in either the parent- or child-report data predicted symptoms on the Anxious/Depressed scale. When comparing clinical levels of depressive symptoms on each scale of the outcome ASEBA scales, a higher percentage of cases scored above clinical cutoffs on the Withdrawn/Depressed scale than the Anxious/Depressed scale in both the parent- and child-report data, and not a single parent reported their child was above the clinical cutoff on the Anxious/Depressed scale. Child responses on the outcome Anxious/Depressed scale were also positively skewed and leptokurtic, meaning youth endorsed fewer than expected items and scores clustered around middle values more than would be expected if it were normally distributed. These findings indicate that youth coping with family conflict predicts symptoms on the Withdrawn/Depressed scale more than the Anxious/Depressed.

This discrepancy in the correlations with outcome measures could be because the Withdrawn/Depressed scale does not include items that were designed to tap into anxiety (e.g., "Fears he/she might think or do something bad"). Previous researchers have found that primary

control youth coping was significantly associated with youth depressive symptoms but not with anxiety symptoms on the CBCL/YSR (Bettis et al., 2016). In addition, it may be that coping with family conflict is especially predictive of the withdrawal, anhedonia, and psychomotor retardation symptoms of depression exclusively measured by the Withdrawn/Depressed scale of the ASEBA (e.g., "Would rather be alone than with others", "There is very little he/she enjoys", "Underactive, slow moving, or lacks energy"). It is worth noting that parent-report of Outcome Withdrawn/Depressed was not found to be significantly positively correlated with the CES-D measure of youth depressive symptoms. In comparison to the CES-D that assesses a wide range of depressive symptoms, the vast majority of items on the Withdrawn/Depressed scale ask about social withdrawal symptoms.

These results suggest that using primary control coping with family conflict is especially protective against the withdrawal symptoms of depression in Latinx youth. This especially makes sense given this stressor is interpersonal in nature – if youth don't attempt to actively address and resolve conflict with family members, they might avoid family members and develop social withdrawal symptoms of depression. This could be especially detrimental in this cultural group due to the cultural importance of family relationships (Germán, Gonzalez, & Dumka, 2009). It is possible that within Latinx families, due to the cultural values of collectivism and *familismo*, it is more adaptive for youth address family conflict through primary control coping.

Since this longitudinal study controlled for baseline depressive symptoms, it is also possible that the very strong correlation between baseline and outcome depressive symptoms did not allow for other correlations between coping variables and outcome depression to emerge in the models. Previous cross-sectional research might have inflated the correlation between youth

coping and depressive symptoms. In the meta-analysis by Compas et al. (2017), the authors found that only coping variables that positively predicted depressive symptoms (e.g., disengagement coping) were significant in longitudinal studies. They urged that more longitudinal research is needed to determine whether this finding was simply a product of having a small body of evidence to examine. The present study provides needed longitudinal evidence that at least primary control youth coping in the context of family conflict can protect against later depressive symptoms in youth, even when controlling for baseline youth depressive symptoms.

No type of child-reported youth coping predicted any measure of outcome depressive symptoms. As previously noted, nonsignificant correlations with child-report of coping variables might be in part due to the lack of consistency between parent and child responses on the RSQ that were discovered. Though this discrepancy between parent and child models was unexpected given prior findings with the RSQ (Compas et al., 2017), they were not entirely surprising in the context of the broader literature on informant discrepancies (e.g., Achenbach, McConaughy, & Howell, 1987).

Research Question 4

The fourth research question examined whether coping suggestions in the context of family conflict predicted youth depressive symptoms. As predicted, parent-report of both primary and secondary control coping suggestions significantly negatively predicted parent-report of Withdrawn/Depressed symptoms in almost every model. This was one of the most consistently significant effects in analyses. This finding aligns with prior evidence that primary and secondary control coping suggestions can protect against youth depressive symptoms (Abaied & Rudolph, 2010). This is especially encouraging given the previously described

finding that secondary control coping suggestions were not significantly associated with secondary control youth coping (see Research Question 2). These results provide promising evidence that speaking with Latinx youth about family conflict and recommending strategies for both managing and adapting to these stressors can help protect against later depressive symptoms, even if youth do not implement parents' coping suggestions.

Contrary to hypotheses, parent-report of disengagement coping suggestions did not positively predict later youth depressive symptoms. This could be because youth in this sample received a moderate or high amount of engagement coping suggestions. Abaied and Rudolph (2010b) found that disengagement coping suggestions were only significantly positively associated with depressive symptoms when children received low (not moderate or high) levels of engagement coping suggestions. Given this author's theory that the SOC might tap into parental directiveness in Latinx parents (Ispa et al., 2013; Halgunseth, 2019), it is possible that this sample of parents provided a high level of both engagement and disengagement coping suggestions, which provided a buffer. However, the lack of correlation between parent-report of disengagement coping suggestions and youth depressive symptoms could also be because youth in the sample were experiencing a low or moderate amount of family conflict. Abaied and Rudolph (2010b) found that only when youth were faced with high interpersonal stress, were disengagement coping suggestions significantly associated with depressive symptoms.

Again, it is notable that coping suggestions only significantly predicted symptoms on the Withdrawn/Depressed scale and not on the Anxious/Depressed scale. These results provide evidence that parental suggestions for how to cope with family conflict is especially predictive of withdrawal symptoms of depression in Latinx youth. Clinical implications for this will be addressed later in the document.

No type of child-reported coping suggestion predicted youth depressive symptoms in this study. Similar to previously described hypotheses regarding informant discrepancies on the RSQ, parents and youth in this population have different perceptions of coping suggestions. Though parent- and child-report of coping suggestions were found to be positively correlated, it is possible that parents believe they are making a higher number or more specific types of coping suggestions, but children in this age range might not fully understand or be aware of parents' coping suggestions.

Research Question 5

The final research question of this study aimed to determine whether parental acceptance predicted later depressive symptoms in youth. Contrary to extensive previous evidence in the general population that parental warm/acceptance protects against youth depressive symptoms (e.g., Gonzales, Pitts, Hill, & Roosa, 2000; Wadsworth et al., 2013), neither parent- nor child-report of parental acceptance predicted either measure of youth depressive symptoms. This result is similar to those of previous studies that have found parental warmth, responsiveness, and acceptance do not predict mental health outcomes for Latinx youth as reliably as non-Latinx White youth (Luis et al., 2008; Varela et al., 2009, 2013). It is important to note that the present study included harsh parenting as a control variable. Therefore, it is possible that parental acceptance does not predict depressive symptoms in Latinx youth when controlling for harsh parenting. In other words, harsh parenting might diminish the protective effects of warm/responsive parenting on youth depressive symptoms. Other variables in the model that were significantly related to depressive symptoms (i.e., baseline depressive symptoms, primary control coping, primary or secondary control coping suggestions) might also have contributed to the lack of significant relationship between parental acceptance and youth depressive symptoms.

A possible indirect path through youth coping will be addressed in a later section. It should also be noted that parent and child responses on the measure of parental acceptance were not significantly correlated, suggesting Latinx parents and youth might perceive this construct differently, which could affect paths with other variables.

Controls Paths

Though not central to hypotheses, results of relationships with control variables included in the models will be briefly summarized. In general, there were more significant relationships with control variables in the child-report than parent-report data.

Harsh Parenting. The present study found that harsh parenting was significantly negatively correlated with parental acceptance in every parent-report model and in child-report models using the Withdrawn/Depressed scale. This conflicts with some prior evidence that less acculturated Mexican American parents are high in both harshness and acceptance (Domenech Rodríguez, Donovick, & Crowley, 2009; Hill, Bush, & Roosa, 2003; White et al., 2013). However, prior studies have found that within samples of low-SES Latinx parents, a significant proportion of parents do not fit this parenting style (Domenech Rodríguez, Donovick, & Crowley, 2009; Hill, Bush, & Roosa, 2003; White et al., 2013). This study did not examine different parenting styles within the sample, so a proportion of these parents might have been high in both acceptance and harshness. It is also possible that this sample was more acculturated than prior samples, and our proxy measures of acculturation did not fully assess for this. Lastly, this finding could be related to heterogeneity in the country of origin. Though over 90% of the sample was Mexican American, there were parents from other countries in the sample. There is evidence that Mexican immigrant mothers use more authoritarian practices than Dominican immigrant mothers (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012), and Puerto Rican

parents use more warmth and consistency in their parenting than Mexican American and Salvadorian parents (De Von Figueroa-Moseley, Ramey, Keltner, & Lanzi, 2006).

In addition, in contrast to expectations and previous findings, harsh parenting did not significantly predict youth depressive symptoms in parent- or child-report models. This aligns with prior evidence that harsh parenting does not predict youth mental health outcomes as reliably in Latinx families and non-Latinx White families (Luis et al., 2008; Varela et al., 2009, 2013). However, this pattern could also be due to the low incidence of clinical levels of depressive symptoms in the sample, or the removal of an item related to physical punishment from the Harsh Parenting scale.

Harsh parenting was found to be significantly negatively correlated with both primary and secondary control youth coping in the parent-report models. Harsh parenting was not significantly correlated with disengagement youth coping in either the parent- or child-report models, and was not significantly associated with any type of youth coping in the child-report data. These results suggest that parent harshness is a risk factor for low use of primary and secondary control coping approaches to family conflict for Latinx youth, and aligns with previous findings that harsh/negative parenting is negatively associated with engagement coping (Eisenberg, Fabes, & Murphy, 1996). As initially theorized, when parents don't use harsh parenting strategies, they likely create an environment that encourages children to use more engagement coping skills. The lack of significant correlation with disengagement coping aligns with prior evidence that parent variables are not strong predictors of disengagement coping in youth (Power, 2004). The previously described discrepancies between parent and child responses on the measure of youth coping likely contributed to the lack of significant associations in the child-report data.

Child-report of harsh parenting was found to be positively correlated with all three types of coping suggestions in all child models, including disengagement coping suggestions. This relationship was not significant in parent-report models. Taken together with the positive correlations between parental acceptance and all three types of coping suggestions, these results provide further evidence that the SOC measure of coping suggestions might tap into a parenting construct, especially for the youth self-report version. It is possible that children who view their parents as simply highly involved in their lives rate their parents as high in both harshness and the coping suggestions domains. Something akin to parental directiveness (Ispa et al., 2013) or protective parenting (Domenech Rodríguez, Donovick, & Crowley, 2009), which have been identified as common aspects of Latinx parenting, could be a hidden explanatory variable that drives both parent harshness and parent use of coping suggestions in Latinx families. Perhaps providing coping suggestions is a way parents involve themselves in children's lives and attempt to protect their children. Researchers have theorized that directiveness could be a way of conveying caring and a desire for connection within Mexican American culture (Ispa et al., 2013).

Child Gender. Significant gender differences between boys and girls appeared only for child-report of primary control coping. Girls self-reported significantly higher levels primary control coping than boys. This aligns with previous evidence that females are more likely to use primary control coping strategies than male youth (Nicolotti et al., 2003). It is also interesting that a prior study found that primary control coping with family conflict was protective against internalizing symptoms for girls in low-income families but not boys (Santiago & Wadsworth, 2009), and suggests primary control coping might be more intuitive and adaptive for Latinx females.

Child gender did not significantly predict any parent-report variables, any coping suggestions variables, or child-report of secondary control or disengagement coping. It was somewhat surprising there were not significant gender differences in depressive symptoms, but this could be due to the young age of the sample, as previously described (Wade, Cairney, & Pevalin, 2002).

Parent Depressive Symptoms. As expected, parent depressive symptoms significantly negatively predicted parental acceptance in all parent-report models. This fits with extensive evidence that parent depressive symptoms impede positive parenting (Goodman et al., 2011). However, this relationship was not significant in child-report models, perhaps due to children's limited awareness of their parents' private feelings.

Parent depressive symptoms also positively predicted child-report of disengagement coping, but did not predict child-report of primary or secondary control youth coping, or parent-report of any youth coping variables. The significant association between parent depressive symptoms and youth disengagement coping aligns with prior research findings (Jaser et al., 2011). Previous evidence for the relationship between parent depressive symptoms and primary control youth coping are less consistent in the extant literature (Fear et al. 2009; Jaser et al., 2005), so the lack of association between parent depressive symptoms and primary control coping is not entirely surprising. The lack of association between parent depressive symptoms and secondary control coping is surprising given this has been well-established in the general population (Dunbar et al., 2013; Fear et al. 2009; Jaser et al., 2005). Since secondary control coping with family conflict does not necessarily involve other people (especially compared to primary control coping), parent depressive symptoms might not impede children's use of secondary control coping in this context.

Parent depressive symptoms did not predict youth depressive symptoms. Again, this could be due to the low incidence of clinical levels of depressive symptoms in the sample, the many control variables, and the strong associations between youth outcome depressive symptoms and other variables.

Lastly, parent depressive symptoms did not predict any type of parental coping suggestion in either the parent- or child-report data. This result was especially surprising, given parent depressive symptoms was negatively associated with parental acceptance. This could indicate that while parent depressive symptoms can impair parental acceptance, it may not be as impairing to parents' ability to provide coping suggestions.

Baseline Youth Depressive Symptoms. As expected, baseline measures of youth depressive symptoms significantly positively predicted their respective outcome measure of youth depressive symptoms in all parent- and child-report models. However, parent-report of baseline youth depressive symptoms did not predict any other parent-reported variable. As mentioned previously, this discrepancy between parent- and child-report is likely due to parents being less aware of children's private feelings (e.g., Achenbach, McConaughy, & Howell, 1987; Lau, Garland, Yeh, Mccabe, Wood, & Hough, 2004).

For the child-report models, baseline Withdrawn/Depressed (but not Anxious/Depressed) negatively predicted parental acceptance. Given the timing of the longitudinal study, these results suggest that youth with higher baseline depressive symptoms received less warm/accepting parenting, which aligns with recent research suggesting there is a bidirectional effect between parenting and youth characteristics (e.g., Taraban, 2018; Hastings et al., 2019). However, it is also possible that youth received parenting that was low in warmth/acceptance even prior to the assessment of baseline depressive symptoms, so the original direction of the relationship

between these variables for this sample is not clear. In addition, this discrepancy in results between the Withdrawn/Depressed and Anxious/Depressed scales might indicate that withdrawn symptoms in youth negatively affect parental acceptance more strongly by than anxious symptoms for this population. This aligns with prior research on the differential effects of childhood depression and childhood anxiety on parenting (Hastings et al., 2019). The lack of correlation in the parent-report data is likely in part due to the lack of significant correlation between parent and child responses on the Baseline Withdrawn/Depressed scale.

The relationship between baseline youth depressive symptoms and youth coping was somewhat surprising given other findings of the study. As expected, child-report of both baseline Withdrawn/Depressed and Anxious/Depressed symptoms positively predicted disengagement youth coping in all child-report models. This aligns with extensive prior evidence that depressive symptoms are associated with disengagement coping (e.g., Compas et al., 2017). However, child-report of baseline Anxious/Depressed symptoms – not Withdrawn/Depressed symptoms – significantly negatively predicted primary control youth coping in most child-report models. This is interesting given the previously described findings for the relationship between youth coping and outcome depressive symptoms: recall, parent-report of primary control youth coping significantly negatively predicted outcome Withdrawn/Depressed symptoms, and no type of parent- or child-reported youth coping predicted outcome Anxious/Depressed symptoms. This inconsistency could be due to informant discrepancies, but could also be indicative of the temporal relationship between anxious and depressive symptoms. It is possible that initial symptoms of anxiety impair primary control coping in youth, and these impaired coping skills contribute to depressive symptoms. This aligns with extensive evidence in the field of developmental psychopathology that anxious symptoms tend to precede depressive symptoms in

youth (Brady & Kendall, 1992). Perhaps youth who scored higher on the Anxious/Depressed scale felt more fearful of potential negative consequences of attempting to address family conflict, and therefore were more reluctant to use primary control coping. Lastly, no measure of baseline youth depressive symptoms significantly predicted secondary control youth coping. It is possible that depressive symptoms in this population of youth do not impair their ability to use secondary control coping with family conflict when accounting for the impact of other variables that were identified (i.e., parental acceptance and harsh parenting).

Lastly, baseline youth depressive symptoms did not predict any type of coping suggestion in parent- or child-report models. Again, it is possible the strong correlation between baseline and outcome youth depressive symptoms did not allow for correlations with other variables in the model to emerge as significant. It is also possible that youth depressive symptoms do not contribute parents' use of coping suggestions in this population. Perhaps this population of parents is able to make suggestions for how to cope with family conflict regardless of children's emotional receptiveness, and are not deterred by children's withdrawal symptoms.

Other Mediation Paths

Three indirect paths that are not central to hypotheses but are part of the conceptual model were also examined. First, parent-report of primary control suggestions and secondary control suggestions negatively mediated the relationship between parental acceptance and Withdrawn/Depressed symptoms. This means that high parental acceptance predicted high levels of primary and secondary coping suggestions (Research Question 2), and each of these predicted low Withdrawn/Depressed symptoms in the parent-report data. These indirect paths fit with expectations, but were somewhat surprising given the previously described finding that parental acceptance did not have a direct effect on youth depressive symptoms (see Research Question 5).

This could indicate that the impact of parental acceptance on youth depressive symptoms is partially mediated by coping suggestions for this population. In addition, none of these mediation pathways were significant in models using the Anxious/Depressed scale or in any child-report models – this provides further evidence that the Withdrawn/Depressed scale taps into depressive symptoms especially impacted by coping suggestions for this population.

Second, contrary to expectations, youth coping did not mediate the relationship between parental acceptance and youth depressive symptoms in any parent- or child-report model. Given parental acceptance was found to predict all types of youth coping in the expected directions in the child- but not parent-report models (see Research Question 1), and primary control youth coping negatively predicted youth depressive symptoms in the parent- but not child-report models (see Research Question 3), informant discrepancies are likely primarily to blame for this lack of significance. Therefore, it is possible that primary control youth coping, but not secondary control or disengagement youth coping, mediate the relationship between parental acceptance and depressive symptoms in Latinx youth experiencing family conflict. Again, this could be because primary control coping is more effective than secondary control coping in the context of family conflict for this population.

Lastly, the four-variable indirect effect from parental acceptance to coping suggestions, youth coping, and outcome youth depressive symptoms was examined. This mediating relationship was only significant for one parent model: primary control coping suggestions and primary control youth coping negatively mediated the relationship between parental acceptance and Withdrawn/Depressed symptoms. This means that high parental acceptance predicted high primary control coping suggestions, high primary control coping, and low Withdrawn/Depressed symptoms. This result fits with the previously described significant paths and implies that

primary control approaches to coping with family conflict might be more transmissible through explicit suggestions than other coping skills in Latinx families. This finding also suggests that primary control coping might have a stronger effect on youth depressive symptoms that other types of coping for this population in the context of family conflict.

Limitations

There are several limitations to this study. First, the amount of family conflict experienced by the child was not examined in the present study. Previous research suggests that the level of stress can moderate the relationship between coping suggestions and mental health outcomes (Abaied & Rudolph, 2010). Including a measure of amount of family conflict in analyses could potentially help explain why parent-report of disengagement coping suggestions and child-report of any type of coping suggestion did not predict youth depressive symptoms. However, this was beyond the scope of the present study.

Second, the present study includes cross-sectional elements. Parental acceptance, harsh parenting, coping suggestions, and youth coping were all collected at the same time point. Therefore, it is impossible to be certain about the directionality between these variables. Ideally, each predictor variable should be collected at a separate timepoint. This limitation in the methodology could also at least partially explain why many of the mediation and direct paths were not significant. In addition, there is evidence of delayed effects of coping and parenting on youth outcomes (e.g., Santiago & Wadsworth, 2009), so the six-month interval between the assessment of the predictor variables and outcome depressive symptoms might be too brief.

Third, this sample had multiple specific characteristics that could limit the applicability of findings to other Latinx communities. Cross-cultural researchers have recommended that increased attention be paid to variations within the heterogeneous population of Latinx families

(Hall, Yip, & Zárate, 2016; Heppner, 2008; Hill, Bush, & Roosa, 2003). The sample of parents was predominantly low-income, of Mexican-descent, Spanish-dominant, first generation (born outside the U.S.), and biological mothers. Researchers have found that parenting and its relationship to child outcomes often vary more by socioeconomic status than ethnicity (e.g., Hill, Bush, & Roosa, 2003). It is therefore possible that these findings do not hold for Latinx families at different income levels. There was some heterogeneity in country of origin in the sample, but the sample was not large enough to examine differences between these groups. Existing research has found that country of origin may play a role in predicting parenting. For example, Mexican immigrant mothers may use more authoritarian practices than Dominican immigrant mothers (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012), and Puerto Rican parents may use higher warmth and consistency in their parenting than Mexican American and Salvadorian parents (De Von Figueroa-Moseley, Ramey, Keltner, & Lanzi, 2006). In addition, there is also evidence that mothers' and fathers' parenting has different impacts on youth depressive symptoms (García et al., 2014). Lastly, the majority of participating families were recruited from charter schools, and it is possible the parenting practices of caregivers who enroll their children in charter schools differ in meaningful ways from other parents (e.g., increased involvement or directiveness). Though this study provides an important step in better understanding the relationship between parenting, coping suggestions, youth coping, and youth depressive symptoms in Latinx families, future research should examine differences within this diverse population.

Fourth, though the present study assessed parent acculturation through proxy variables (language preference and generation status), parent level of acculturation was not included as moderating variable in analyses. At this time, it is unknown whether parents' level of

acculturation moderates the relationships between parenting, coping suggestions, and youth coping in this population. Given prior evidence that Latinx parents who are less U.S.-acculturated use more authoritarian parenting (e.g., Parke et al., 2004), together with the hypothesis that the SOC measure of coping suggestions might be tapping into the parenting dimension of directiveness, it is possible that less acculturated parents make more coping suggestions.

Fifth, due to the small sample size, path analyses were utilized instead of structural equation modeling. Research suggests that structural equation modeling is the preferred method when testing multiple interactions (Rowe, Vazsonyi, & Flannery, 1994). The small sample size likely also contributed to the lack of variability and severity in depressive symptomatology in the sample.

Sixth, preliminary analyses suggested that data were not missing completely at random (MCAR) and could therefore be either missing at random (MAR) or missing not at random (MNAR). Results indicated that cases with any missing data were significantly more likely than those with no missing data to have higher scores of child-reported Baseline Anxious/Depressed symptoms. There is no test to determine whether data are MAR or MNAR, so it is impossible to determine whether missing data varied systematically from collected data (Eekhout, 2020). As is generally recommended, data were presumed to be MAR for the purposes of the study, but future analyses should ideally model the missing data mechanism as part of the estimation process (Alison, 2001).

Seventh, examination of parent- and child-data in separate models does not allow for examination of associations between variables across informants. This creates the risk that significant association are confounded by shared method variance (Compas et al., 2017).

Lastly, the back-translation method used by the research team to translate the SOC & RSQ to Spanish might not have produced linguistically accurate or culturally valid measures for present the sample. These translations had not previously been tested with a Latinx sample, so translations of these measures would likely benefit from a focus group discussion and factor analysis.

Strengths

The present study is unique for several reasons. First, the present study contains several unique methodological components. The majority of the existing research on youth coping has been cross-sectional (Compas et al., 2017), which makes it impossible to make any conclusions about the direction of relationships between variables. Though longitudinal data does not provide strong evidence for causal relationships, it does provide information about the temporal relationship between variables. By measuring youth depressive symptoms six months after measuring other variables of interest, the present study illustrates how parenting, coping suggestions, and youth coping might predict depressive symptoms after controlling for baseline levels of symptoms. The inclusion of baseline depressive symptoms and parent depressive symptoms as control variables are particularly rigorous elements of the study not included in many studies. The present study also incorporates multi-informant data by including parent- and child-report of all independent and dependent variables. Reliance on the same informant to assess multiple constructs (parenting, coping suggestions, youth coping, and youth depressive symptoms) increases the chances of the associations between these variables being artificially inflated and confounded by shared method variance. Given this, leading coping researchers have called for an increased use of multiple informants in the field (Compas et al., 2017). In addition, compared to many prior studies in the coping and parenting fields, the present study utilizes

measures with strong empirical support. Lastly, limited research on coping suggestions has examined the effects of primary and secondary control separately.

Second, the present study integrates multiple existing theoretical models to examine the relationships among parenting, parental coping suggestions, youth coping, and youth depressive symptoms. The proposed model includes several established relationships, including between parenting and coping suggestions (Watson et al., 2013), parenting and youth coping (Watson et al., 2014), and coping suggestions and youth coping (Abaied & Rudolph, 2010). However, no previous model has included all mentioned variables in a single model. The hypothesis that parent coping suggestions mediate the relationship between parental acceptance and youth coping is a particularly novel component of the proposed model that has not been previously studied.

Third, the present study examines coping and coping suggestions in the context of a stressor that has not been well studied. The majority of exiting studies in the coping literature assess coping skills broadly independent of a specific stressor, but contemporary researchers have found that different coping strategies are adaptive with different types of stressors (Abaied & Rudolph, 2010). Family conflict (e.g., Céspedes & Huey, 2008; Deardorff, Gonzalez, & Sandler, 2003; Hovey & King, 1996; Seidman et al., 1999) and how youth cope with family conflict (Wadsworth & Compas, 2002) have each been shown to be strong predictors of youth depressive symptoms. However, few studies have examined how parents' suggestions for how to cope with family conflict predict youth depressive symptoms. In addition, little research has examined how parent coping suggestions in general predict youth depressive symptoms within the Latinx population. The bulk of existing research on coping suggestions has focused on stressors outside the home or over which the child has no control (e.g., bullying, financial stress,

chronic illness). Given the cultural value of *familismo* (Germán, Gonzalez, & Dumka, 2009) in Latinx cultures, it is important to understand what types of coping and coping suggestions are protective for this population of youth when faced with family conflict, in particular.

Lastly, the present study focuses on a population of youth at increased risk for depression for which the relationships between parenting, coping suggestions, youth coping, and depressive symptoms are not well understood. Latinx families often experience multiple and unique stressors (e.g., poverty, acculturative stress, immigration) which have been found to be associated with high rates of depressive symptoms in Latinx youth (Céspedes & Huey, 2008; Costello et al., 2003; Deardorff, Gonzalez, & Sandler, 2003; Goodman et al., 2003; Najman et al., 2010; Kuo, 2014). Previous cross-cultural research has found that the relationships between parenting, coping, and youth depressive symptoms may in some ways be different for Latinx compared to non-Latinx families (e.g., Gonzales, Pitts, Hill, & Roosa, 2000; Luis et al., 2008; Varela et al., 2009, 2013), but these differences may be due to other demographic and cultural variables (e.g., Calzada, Huang, Anicama, Fernandez, & Brotman, 2012).

Given these findings, there is need for studies that examine the relationships between these variables for Latinx families. No previous study has examined the relationships between parenting, parent coping suggestions, youth coping and youth depressive symptoms simultaneously in Latinx families. In addition, contemporary researchers have argued that cross-cultural research has historically been excessively focused on defining how racial and ethnic groups are dissimilar, rather than examining intragroup variations (Hall, Yip, & Zárate, 2016). Researchers in the fields of both parenting (e.g., Hill, Bush, & Roosa, 2003) and coping (e.g., Heppner, 2008) have called for increased attention to how important demographic variables within the heterogeneous population of Latinx families may affect the relationship between

parenting, coping, and youth depressive symptoms. Therefore, the present study focused on exploring the relationships among mentioned variables in this specific population of predominantly low-income, Mexican American families living in the same community.

Directions for Future Research

Future research should address the methodological limitations of the present study. First, future studies should gather additional longitudinal data by measuring all included variables at multiple time points in order to better understand the temporal relationships between variables, control for baseline levels, and determine whether any bidirectional relationships between variables exist. For example, parenting researchers are increasingly noting bidirectional relationships between parenting and child behavior (e.g., Taraban, 2018; Hastings et al., 2019). In addition, the relationship between youth coping and youth depressive symptoms appears to be cyclical (e.g., Rudolph, Flynn, & Abaied, 2008). It would be especially helpful to understand whether bidirectional relationships exist between parenting and youth coping for this population in order to develop strategies for interrupting maladaptive cycles.

Second, due to the large number of potential moderating variables (e.g., race, country of origin, parent gender, SES, generational status, language ability, acculturation level, acculturation discrepancy), future studies should utilize more diverse samples of Latinx families and examine the role of additional moderating variables in predicting the relationships between parenting, youth coping, coping suggestions, and youth depressive symptoms.

Third, given prior research has found that the level of stress can moderate the relationship between coping suggestions and mental health outcomes (Abaied & Rudolph, 2010), future research should assess the role of the type and amount of stress in predicting these relationships in this population. Additional studies are needed to determine whether the level of family

conflict moderates the relationships between the variables of interest, and whether other stressors (e.g., discrimination, immigration) yield different pathways.

Fourth, since models were run separately for parent- and child-report data and correlations were not run between parent- and child-report data, it is possible that informant discrepancies are currently hiding meaningful relationships between variables. Examining relationships across parent- and child-report data may yield additional significant paths relevant to the research questions and address the potential confound of shared method variance (Jaser et al., 2005).

Fifth, the hypothesis that parent coping suggestions mediate the relationship between parental acceptance and youth coping should be examined in larger and culturally diverse samples to determine if there is cross-cultural evidence for this relationship. The present study provides evidence that primary control coping can be transmitted to youth through coping suggestions, but the path was not significant for secondary control coping. This is an important finding, as prior studies using the SOC measure have not examined primary control separately from engagement coping (Abaied & Rudolph, 2011). Given that secondary control coping is more cognitive and less easily observable through behavior than primary control coping, it might not be easily taught through simple modeling. Therefore, future research should continue to explore how Latinx parents can best support their children to develop secondary control coping skills.

Sixth, these findings reveal limitations to the empirical utility of the SOC measure. Unlike the RSQ measure of coping, the SOC measure of coping suggestions produces mean scores rather than relative proportion scores for each domain. It does not control for respondents who are simply more likely to endorse items across subscales. This limits researchers' ability to

compare the strength of a given variable's association with specific types of coping suggestions. Unlike measures of parenting for which discreteness between subscales has been recommended by researchers (e.g., White, Roosa, Weaver & Nair, 2009), measures of coping suggestions may yield more scientifically meaningful results if they assess the relative proportion of each type of coping suggestion.

Lastly, future research should examine causal relationships between variables in a randomized treatment trial of a culturally relevant coping skills intervention for this population. A growing body of coping research has begun to use interventional designs, but more is needed (Compas et al., 2017).

Clinical Implications

Though the present study has limitations and findings are mixed, the results of this study have direct implications for clinicians working with Latinx families. In addition to having among the highest rates of depressive symptoms and suicidality, Latinx youth are part of the largest and youngest minority groups in the U.S., as well as one of the fastest growing (U.S. Census Bureau, 2016). Mexican Americans represent the largest Latinx population in the U.S., with over 60% of Latinos being of Mexican descent (U.S. Census Bureau, 2019). From a public health perspective, it is important to understand the risk and protective factors associated with depressive symptoms in this community in order to develop culturally informed preventative interventions. Subclinical symptoms of depression in youth often present multiple years before meeting diagnostic criteria for MDD (National Research Council and Institute of Medicine, 2009), which provides an important window of opportunity for preventative intervention. In addition to helping promote mental health in Latinx families and protecting Latinx youth against the risks associated with

depressive symptoms, findings from this study could contribute to lowering societal costs associated with caring for depressed and suicidal youth.

First, the present study provides important evidence about the appropriateness of primary control coping for family conflict in this population. Primary control coping with family conflict – not secondary control – protected against depressive symptoms in this sample. This aligns with prior evidence from an ethnically diverse sample of low-SES youth that primary control coping with family conflict can protect against internalizing symptoms (Santiago & Wadsworth, 2009). Changing their thinking about family conflict (secondary control coping) might not be as helpful as changing their behavior or emotional expression regarding family conflict (primary control) for Latinx youth. These results also suggest that engaging with family conflict is especially protective against the withdrawal symptoms of depression in Latinx youth, in comparison to anxious/depressive features. It is possible that when youth directly address and resolve conflict with family members, this might prevent them from avoiding family members and developing withdrawal symptoms of depression. Results from the present study also showed that girls were more likely than boys to use primary control coping, which aligns with prior findings of the prevalence (Nicolotti et al., 2003) and adaptiveness of primary control coping with family conflict across genders (Santiago & Wadsworth, 2009). Taken together, these results suggest primary control coping with family conflict is adaptive for Latinx adolescents, and might be especially intuitive for Latinx females. When attempting to prevent the development of depression in Latinx adolescents, it might be especially important for clinicians to emphasize primary control coping skills for dealing with family conflict.

Second, the present study provides important evidence regarding the impact of parent coping suggestions on youth. Parents' primary control coping suggestions were associated with

high primary control coping, low disengagement coping, and low withdrawal symptoms of depression in youth. This suggests that teaching children to use primary control coping through direct instruction might be effective and protective. Although secondary control coping suggestions were not significantly correlated with secondary control coping in youth, secondary control coping suggestions did negatively predict later youth depressive symptoms. It is possible that regardless of whether parents give primary or secondary control coping suggestions, or whether children appear to use that specific coping strategy, conversations about coping might at minimum prevent children from disengaging with family conflict. This is important because previous research has shown disengaging from high interpersonal stress can be harmful to youth mental health (e.g., Abaied & Rudolph, 2010). These results align with prior evidence that engagement coping suggestions can protect against depressive symptoms (Abaied & Rudolph, 2010b). The lack of correlation between disengagement coping suggestions and later youth depressive symptoms suggests that this sample of parents might have provided a moderate or high amount of engagement coping suggestions, which buffered against the harmful effects of disengagement coping on youth depressive symptoms that has been demonstrated in prior studies (Abaied & Rudolph, 2010b). This also aligns with the author's theory that the SOC might be tapping into a measure of parental directiveness, which has been found to be protective in Latinx families (Halgunseth, 2019). Taken together, the results of this study suggest that clinicians should encourage parents to provide coping suggestions to youth when experiencing family conflict, and also warn parents to not be discouraged if children do not appear to be following their instructions – simply speaking with children about family conflict and recommending ways to manage it can reduce maladaptive coping.

Third, since parents' suggestions to use secondary control coping did not appear to be associated with youth coping, it could indicate that this teaching approach is not effective for this particular coping skill in this population of youth. Since this correlation has also not been well-established in the general population, it is possible that children across cultural groups need more scaffolding from parents to put secondary control coping skills into practice. For example, there is evidence that teaching strategies other than direct instruction, like Socratic questioning, are effective in teaching skills related to mental health. Socratic questioning is a cornerstone of cognitive-behavioral therapy, including coping skills training for youth, as it promotes awareness, reflection, and problem-solving (Neenan, 2009). Therapist use of Socratic questions have been found to predict reduction in depressive symptoms (Braun et al., 2015). It is possible that parent use of questions rather than instructions might support children's secondary control coping skills.

Fourth, these results indicate that this population of parents might find providing helpful coping suggestions intuitive, even when experiencing depressive symptoms. This study found that both parental acceptance and harsh parenting were positively associated with all three types of coping suggestions. In addition, neither parent depressive symptoms nor youth baseline depressive symptoms significantly predicted any type of coping suggestion. While parental depressive symptoms, youth depressive symptoms, and harshness were each found to be barriers to parental acceptance, they may not impair this population of parents' ability to provide adaptive coping suggestions to their children. This is an important source of resilience for families and clinicians to be aware of.

Fifth, these results suggest that parental acceptance may positively contribute to youth coping in Latinx families. Though parents' secondary control coping suggestions were not

significantly correlated with youth secondary control coping, parental acceptance was positively associated with youth secondary control coping. The results of this study indicate that warm/accepting parenting might support both primary and secondary control coping with family conflict, while harsh parenting might be a barrier to primary and secondary control coping for Latinx youth. This aligns with prior evidence that parental acceptance is positively associated with engagement coping across cultural groups (Gaylord-Harden, 2008; Power, 2004) and suggests the relationship is consistent in low-income Latinx families. It is possible that harsh parenting prevents youth in Latinx families from feeling able or motivated to resolve family conflict. Clinicians seeking to prevent depressive symptoms in Latinx youth might encourage parents to amplify their use of parental acceptance and caution against the risks of parent harshness in this community.

Sixth, parent coping suggestions might mediate the impact of parental acceptance on youth depressive symptom. Though parental acceptance did not have a direct effect on youth depressive symptoms, both primary and secondary control coping suggestions were found to mediate the relationship between parental acceptance and depressive symptoms. This suggests that parental acceptance in this population might lead parents to provide more engagement coping suggestions for coping with family conflict, which in turn protects against depressive symptoms. Clinicians working with Latinx families might encourage caregivers to express acceptance given these indirect benefits. For those parents who struggle with parental acceptance, there is prior evidence that parenting skills interventions have been shown to improve children's coping without directly targeting youth coping (Vélez, Wolchik, Tein, & Sandler, 2011). This is clinically important because single-component interventions can be more

cost effective and efficient than multi-component interventions, and understanding the mechanisms of change are critical to developing effective interventions.

Seventh, these findings are also relevant to understanding the potential impact of both parent and youth depressive symptoms on parenting in this population. Both baseline parent depressive symptoms and baseline youth depressive symptoms negatively predicted parental acceptance. These findings fit with extensive evidence that parent depressive symptoms can impede positive parenting (Goodman et al., 2011), and the relationship between parenting and youth characteristics is bidirectional (e.g., Taraban, 2018; Hastings et al., 2019). When treating youth and providing parenting skills interventions, in order to maximize the impact of these child-focused interventions, it is prudent to ensure parents with depressive symptoms are also receiving mental health care. This context is also important for clinicians to be aware of so they can provide accurate psychoeducation on the impact of parenting on children, the impact of child depression on parenting, and culturally relevant parenting recommendations.

Eighth, many of these results have implications for including caregivers in interventions aimed at preventing depression in Latinx youth. Rather than taking the commonly used individual approach to addressing youth depressive symptoms (Ford-Paz, et al., 2015), focusing on familial relationships, parent-adolescent communication, and collaborative coping might be especially culturally acceptable to Latinx parents given the cultural values of collectivism and *familismo* (Germán, Gonzalez, & Dumka, 2009). Clinical researchers have found that both parents and adolescents in Latinx families expect caregivers to be included in therapy for adolescents experiencing depression (Zayas & Pilat, 2008). Emerging research on culturally informed preventative interventions for Latinx youth suggest that culturally tailored interventions that involve caregivers in treatment might be especially beneficial for Latinx youth at high risk

for depression. Results of perhaps the only family-based intervention designed specifically to prevent risky substance use and sexual behaviors in Latinx adolescents, called *Familias Unidas,* demonstrated unanticipated reductions in internalizing symptoms in Latinx youth (Brick et al., 2018). Youth at the highest risk for depression and with low levels of parent-adolescent communication especially benefited, and increased communication mediated the intervention's effects on internalizing symptoms (Perrino et al., 2014). Increasing communication between parents and adolescents might be key to interrupting the development of clinical depression for Latinx youth. The results of the present study shed light on a specific topic for conversation that might be especially protective against depression for Latinx youth. Encouraging Latinx parents and adolescents to discuss examples of family conflict and collaboratively develop plans for addressing disagreements between family member could help protect against depressive symptoms in this population.

Lastly, in thinking about the needs of community-based clinicians serving this population and the importance of promoting evidence-based practice, it could be helpful to have a measure of parent coping suggestions freely available to support identification of relevant treatment targets for youth at risk for depression. The findings from the present study suggest the SOC measure of coping suggestions has many benefits, but also produces mean scores rather than relative proportion scores for each domain of coping suggestions. It would be especially helpful to have an easily administered measure that indicates which type of coping suggestions parents make more of in order to identify targets of treatment.

Conclusion

The current study sought to understand the relationships between youth depressive symptoms, parenting, parent coping suggestions, and youth coping with family conflict in Latinx

families. A sample of predominantly Mexican American, low-SES, early adolescent, Latinx youth and their parents completed measures at three time points over the course of a year. Support for the hypothesized models was mixed. The results of the study indicated that primary control coping with family conflict might be especially protective against depressive symptoms for Latinx youth. Parent-report of primary control youth coping with family conflict and parent-report of primary and secondary control coping suggestions negatively predicted youth depressive symptoms six months later. In addition, coping suggestions were not found to consistently correlate with youth coping: only parent-report of primary control coping suggestions was positively correlated with primary control youth coping, and child-report of primary control coping suggestions was negatively correlated with disengagement youth coping. Child-report of parental acceptance was positively correlated with both primary and secondary control youth coping, and was negatively correlated with disengagement youth coping. Parental acceptance was positively correlated with every type of parent coping suggestion in both the parent- and child-report data. In regards to the mediation hypothesis, only parent-report of primary control coping suggestions mediated the relationship between parental acceptance and primary control youth coping. Contrary to expectations, parental acceptance did not predict youth depressive symptoms. It is recommended that future research continue to investigate the proposed theoretical model by addressing methodological limitations in this study and retaining important strengths of the design. The results of this longitudinal study have implications for clinicians working with Latinx youth and their caregivers. Findings are relevant to understanding the development of depressive symptoms in this population, and can help inform culturally relevant, family-focused preventative interventions and treatments for Latinx youth at risk for depression.

Appendices

Appendix A

Items in Measures of Youth Depressive Symptoms

CBCL/YSR Anxious/Depressed Items

1. Cries a lot
2. Fears certain animals, situations, or places other than school
3. Fears going to school
4. Fears he/she might think or do something bad
5. Feels he/she has to be perfect
6. Feels or complains that no one loves him/her
7. Feels worthless or inferior
8. Nervous, highstrung, or tense
9. Too fearful or anxious
10. Feels too guilty
11. Self-conscious or easily embarrassed
12. Talks about killing self
13. Worries

CBCL/YSR Withdrawn/Depressed Items

1. There is very little he/she enjoys
2. Would rather be alone than with others
3. Refuses to talk
4. Secretive, keeps things to self
5. Too shy or timid
6. Underactive, slow moving, or lacks energy
7. Unhappy, sad, or depressed
8. Withdrawn, doesn’t get involved with others

CBCL/YSR Internalizing Problems Items

(All items from Anxious/Depressed and Withdrawn/Depressed subscales)

CES-D Items

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family.
4. I felt that I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.

6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
14. I felt lonely.
15. People were unfriendly.
16. I enjoyed life.
17. I had crying spells.
18. I felt sad.
19. I felt that people disliked me.
20. I could not "get going."

Appendix B

Response to Stress Questionnaire (RSQ) – Family Stress Version (English Child-Report)

Date: _____

ADOLESCENT/CHILD'S SELF-REPORT RESPONSES TO STRESS – [FS]

Even when things are going well for kids and teenagers, almost everyone still has some tough times getting along with people in their family, like parents, step-parents, and brothers and sisters. So that we can find out how things have been going for you lately, please circle the number indicating how stressful the following things have been for you in the last 6 months.

	Not at All	A Little	Somewhat	Very
a. Arguing with your mother	1	2	3	4
b. Arguing with your father	1	2	3	4
c. Your parents arguing with each other	1	2	3	4
d. Competing with your sibling(s)	1	2	3	4
e. Your parents not understanding you	1	2	3	4
f. Having a hard time talking with your parents	1	2	3	4
g. Your parents hassling or nagging you	1	2	3	4
h. Arguing or fighting with your sibling(s)	1	2	3	4
i. Not being as close to your sibling(s) as you'd like	1	2	3	4
j. Your sibling(s) messing up, breaking, or taking your belongings	1	2	3	4
k. Not spending as much time as you would like to with your parents	1	2	3	4
l. Having other kinds of problems with your parents	1	2	3	4

Explain _____

***** Circle the number that shows how much control you think you have over these problems.**

1 None | 2 A little | 3 Some | 4 A lot

Below is a list of things that people sometimes do, think, or feel when something stressful happens. Everybody deals with problems in their own way - some people do a lot of the things on this list or have a bunch of feelings, other people just do or think a few things.

Think of all the problems that you indicated above. For each item below, circle **one** number from 1 (not at all) to 4 (a lot) that shows **how much** you do or feel these things when you have problems with your family like the ones you indicated above. Please let us know about everything you do, think, and feel, even if you don't think it helps make things better.

WHEN DEALING WITH THE STRESS OF PROBLEMS IN MY FAMILY:	How much do you do this? Not at all	A little	Some	A lot
1. I **try** not to feel anything.	1	2	3	4
2. When I have problems with my family, I feel sick to my stomach or get headaches.	1	2	3	4
3. I try to think of different ways to change or fix the situation. **Write one plan you thought of:**_____	1	2	3	4
4. When problems with my family happen, I don't feel any emotions at all, it's like I have no feelings.	1	2	3	4
5. I wish that I were stronger, smarter, or more popular so that things would be different.	1	2	3	4

WHEN DEALING WITH THE STRESS OF PROBLEMS IN MY FAMILY:	How much do you do this? Not at all	A little	Some	A lot
6. **I keep remembering** what happened with my family or **can't stop thinking about** what might happen.	1	2	3	4
7. I let someone or something know how I feel. (*remember to circle a number.*) → **Check all you talked to:** ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these	1	2	3	4
8. I decide I'm okay the way I am, even though I'm not perfect.	1	2	3	4
9. When I'm around other people I act like the problems in my family never happened.	1	2	3	4
10. I just **have** to get away when I have problems with my family, I can't stop myself.	1	2	3	4
11. I deal with the problem by wishing it would just go away, that everything would work itself out.	1	2	3	4
12. I get really jumpy when I'm having problems with my family.	1	2	3	4
13. I realize that I just have to live with things the way they are.	1	2	3	4
14. When I have problems with my family, I just **can't** be near anything that reminds me of the situation.	1	2	3	4
15. I **try** not to think about it, to forget all about it.	1	2	3	4
16. When problems with my family come up I really don't know what I feel.	1	2	3	4
17. I ask other people or things for help or for ideas about how to make the problem better. (*remember to circle a number.*) → **Check all you talked to:** ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these	1	2	3	4
18. When I'm having problems with my family, I **can't stop** thinking about them when I try to sleep, or I have bad dreams about them.	1	2	3	4
19. I tell myself that I can get through this, or that I'll do better next time.	1	2	3	4
20. I let my feelings out. (*remember to circle a number.*) → **I do this by:** **(Check all that you did.)** ☐ Writing in my journal/diary ☐ Drawing/painting ☐ Complaining to let off steam ☐ Being sarcastic/making fun ☐ Listening to music ☐ Punching a pillow ☐ Exercising ☐ Yelling ☐ Crying ☐ None of these	1	2	3	4
21. I get help from other people or things when I'm trying to figure out how to deal with my feelings. (*remember to circle a number.*) → **Check all that you went to:** ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these	1	2	3	4
22. I **just can't** get myself to face the person I'm having problems with or the situation.	1	2	3	4
23. I wish that someone would just come and get me out of the mess.	1	2	3	4
24. I do something to try to fix the problem or take action to change things. **Write one thing you did:**_____	1	2	3	4

You're half done. Before you keep working, look back at the first page so you remember the aspects of having having a parent with cancer that have been stressful for you lately. Remember to answer the questions below thinking about these things.

WHEN DEALING WITH THE STRESS OF PROBLEMS IN MY FAMILY:	How much do you do this? Not at all	A little	Some	A lot
25. Thoughts about the problems with my family just pop into my head.	1	2	3	4
26. When I have problems with my family, I feel it in my body. *(remember to circle a number.)* → **Check all that happen:** ☐ My heart races ☐ My breathing speeds up ☐ None of these ☐ I feel hot or sweaty ☐ My muscles get tight	1	2	3	4
27. I **try** to stay away from people and things that make me feel upset or remind me of the problem.	1	2	3	4
28. I don't feel like myself when I am dealing with problems in my family, it's like I am far away from everything.	1	2	3	4
29. I just take things as they are; I go with the flow.	1	2	3	4
30. I think about happy things to take my mind off the problem or how I'm **feeling**.	1	2	3	4
31. When problems with my family come up, I **can't stop** thinking about how I am feeling	1	2	3	4
32. I get sympathy, understanding, or support from someone. *(remember to circle a number.)* → **Check all you went to:** ☐ Parent ☐ Friend ☐ Brother/Sister ☐ Pet ☐ Clergy Member ☐ Teacher ☐ God ☐ Stuffed Animal ☐ Other Family Member ☐ None of these	1	2	3	4
33. When problems with my family happen, I **can't** always control what I do. *(remember to circle a number.)* → **Check all that happen:** ☐ I can't stop eating ☐ I can't stop talking ☐ I do dangerous things ☐ I have to keep fixing/checking things ☐ None of these	1	2	3	4
34. I tell myself that things could be worse.	1	2	3	4
35. My mind just goes blank when I have problems with my family, I can't think at all	1	2	3	4
36. I tell myself that it doesn't matter, that it isn't a big deal.	1	2	3	4
37. When I have problems with my family, right away I feel really: *(remember to circle a number.)* → **Check all that you feel:** ☐ Angry ☐ Sad ☐ None of these ☐ Worried/anxious ☐ Scared	1	2	3	4
38. It's really hard for me to concentrate or pay attention when I have problems with my family.	1	2	3	4
39. I think about the things I'm learning from the situation, or something good that will come from it.	1	2	3	4
40 When I have problems with my family, I **can't stop** thinking about what I did or said.	1	2	3	4
41. When I'm having problems with my family, I say to myself, "This isn't real."	1	2	3	4
42. When I'm having problems with my family, I end up just lying around or sleeping a lot.	1	2	3	4

WHEN DEALING WITH THE STRESS OF PROBLEMS IN MY FAMILY:	How much do you do this? Not at all	A little	Some	A lot
43. I keep my mind off problems with my family by: *(remember to circle a number.)* → **Check all that you do:** ☐ Exercising ☐ Seeing friends ☐ Watching TV ☐ Playing video games ☐ Doing a hobby ☐ Listening to music ☐ None of these	1	2	3	4
44. When problems with my family come up, I get upset by things that don't usually bother me.	1	2	3	4
45. I do something to calm myself down when having problems with my family. *(remember to circle a number.)* → **Check all that you do:** ☐ Take deep breaths ☐ Pray ☐ Walk ☐ Listen to music ☐ Take a break ☐ Meditate ☐ None of these	1	2	3	4
46. I just freeze when I have problems with my family, I **can't** do anything.	1	2	3	4
47. When I'm having problems with my family, sometimes I act without thinking.	1	2	3	4
48. I keep my feelings under control when I have to, then let them out when they won't make things worse.	1	2	3	4
49. When problems with my family happen, I can't seem to get around to doing things I'm supposed to do.	1	2	3	4
50. I tell myself that everything will be all right.	1	2	3	4
51. When I have problems with my family, I **can't stop** thinking about **why** this is happening.	1	2	3	4
52. I think of ways to laugh about it so that it won't seem so bad.	1	2	3	4
53. My thoughts start racing when I am having problems with my family.	1	2	3	4
54. I imagine something really fun or exciting happening in my life.	1	2	3	4
55. When I'm having problems with my family, I can get so upset that I can't remember what happened or what I did.	1	2	3	4
56. I try to believe that it never happened.	1	2	3	4
57. When I am having problems with my family, sometimes I **can't** control what I do or say.	1	2	3	4

Appendix C

Response to Stress Questionnaire (RSQ) – Family Stress Version (Spanish Parent-Report)

RSQ FAMILY STRESS - PARENT REPORT OF CHILD - SPANISH Date _____

RESPUESTAS AL ESTRÉS – Estrés en la familia

Aún cuando la vida vaya bien con los niños y adolescentes, casi todos tienen dificultades entendiéndose con familiares, como padres, padrastros y hermanos. Para que podamos entender mejor cómo están las cosas últimamente con su hija/o, por favor marque el número que indique **qué tan estresante** han sido las siguientes situaciones para su hijo/a en los últimos seis meses.

	Nada	Casi nada	Algo	Muy
a. Discutir con su madre	1	2	3	4
b. Discutir con su padre	1	2	3	4
c. Sus padres discuten	1	2	3	4
d. Competir con sus hermano(s)	1	2	3	4
e. Sus padres no lo/a entendien	1	2	3	4
f. Tener dificultad en hablar con sus padres	1	2	3	4
g. Sus padres lo/a fastidian e insisten que haga cosas	1	2	3	4
h. Pelear o discutir con sus hermanos	1	2	3	4
i. No sentirse tan unido/a con sus hermanos como le gustaría	1	2	3	4
j. Sus hermanos dañan, rompen o toman sus pertenencias	1	2	3	4
k. No pasar tanto tiempo con sus padres como le gustaría	1	2	3	4
l. Otro tipo de problemas con sus padres	1	2	3	4

Explique _____

***** Marque el número que representa cuánto control su hijo/a cree que tiene sobre estos problemas.**

1 Nada 2 Casi nada 3 Algo 4 Mucho

Abajo hay una lista de cosas que las personas a veces hacen, piensan o sienten cuando se enfrentan a algo estresante. Cada uno maneja estas situaciones a su manera – algunas personas hacen muchas de las cosas en esta lista o tienen muchos de estos sentimientos, otras personas solo hacen o piensan algunas de estas cosas.

Piense en todas las situaciones estresantes que Ud. marcó arriba para su hija/o. Para cada afirmación abajo, escoja **un** número del 1 (nunca) al 4 (mucho) que indique **qué tanto** ella/él hace o siente estas cosas cuando se enfrenta con el estrés de problemas en su familia, como los que indicó arriba. Por favor, comparta todo lo que su hijo/a hace, piensa y siente aún si Ud. no crea que esto ayude a mejorar las cosas.

CUANDO SE ENFRENTA AL ESTRÉS DE PROBLEMAS EN SU FAMILIA:	¿Con qué frecuencia hace esto? Nunca	Casi nunca	A veces	Mucho
1. Trata de no tener ninguna emoción.	1	2	3	4
2. Cuando tiene problemas con su familia, se siente enfermo/a del estómago o tiene dolores de cabeza.	1	2	3	4
3. Trata de pensar en diferentes maneras de cambiar o arreglar la situación. **Escriba un plan que el/ella haya pensado:** _____	1	2	3	4
4. Cuando tiene problemas con su familia, no siente ninguna emoción, es como si no tuviera sentimientos.	1	2	3	4
5. Desearía ser más fuerte, inteligente o popular para que las cosas fueran diferentes.	1	2	3	4
6. Continua **recordando** que ha pasado con su familia o **no puede dejar de pensar** en lo que podría pasar.	1	2	3	4

CUANDO SE ENFRENTA AL ESTRÉS DE PROBLEMAS EN SU FAMILIA:

	¿Con qué frecuencia hace esto? Nunca	Casi nunca	A veces	Mucho
7. Deja que alguien o algo sepa cómo se siente. (*recuerde marcar un número.*) → **Marque todos con los que habla:** ☐ Padre o madre ☐ Amigo/a ☐ Hermano/a ☐ Mascota ☐ Sacerdote o clérigo ☐ Maestro(a) ☐ Dios ☐ Peluche ☐ Otro familiar ☐ Ninguno de estos	1	2	3	4
8. Decide que está bien tal y como es, aunque no sea perfecto/a.	1	2	3	4
9. Cuando esta rodeado/a de otras personas actúa como si los problemas con su familia nunca hubieran pasado.	1	2	3	4
10. Tiene que alejarse de todo cuando tiene problemas con su familia, no puede dejar de hacerlo.	1	2	3	4
11. Afronta el problema deseando que desaparezca y que todo se arregle solo.	1	2	3	4
12. Se sobresalta fácilmente cuando enfrenta problemas con su familia.	1	2	3	4
13. Se da cuenta que sólo tiene que vivir con las cosas tal y como son.	1	2	3	4
14. Cuando tiene problemas con su familia **no puede** estar cerca de nada que le recuerde de lo que está pasando.	1	2	3	4
15. **Trata** de no pensar en ello, de olvidarlo todo.	1	2	3	4
16. Cuando tiene problemas con su familia realmente no sabe lo que siente.	1	2	3	4
17. Le pide a otras personas o cosas ayuda o ideas acerca de como mejorar las cosas. (*recuerde marcar un número.*)→ **Marque todos con los que habla:** ☐ Padre o madre ☐ Amigo/a ☐ Hermano/a ☐ Mascota ☐ Sacerdote o clérigo ☐ Maestro/a ☐ Dios ☐ Peluche ☐ Otro familiar ☐ Ninguno de estos	1	2	3	4
18. Cuando tiene problemas con su familia no puede parar de pensar en ellos cuando esta tratando de dormir, o tiene pesadillas sobre sus problemas.	1	2	3	4
19. Se dice a si mismo/a que puede superar esto o que va a hacerlo mejor la próxima vez.	1	2	3	4
20. Desahoga sus sentimientos. (*recuerde marcar un número.)* → **Hace esto por medio de: (Marque todo lo que hace.)** ☐ Escribe en un diario ☐ Dibuja o pinta ☐ Se queja para librar tensión ☐ Es sarcástico/a o se burla ☐ Escucha música ☐ Golpea una almohada ☐ Hace ejercicio ☐ Grita ☐ Llora ☐ Ninguno de estos	1	2	3	4
21. Obtiene ayuda de otras personas o cosas cuando esta tratando de encontrar como controlar sus emociones. (*recuerde marcar un número.*) → **Marque todos con los que ha consultado:** ☐ Padre o madre ☐ Amigo/a ☐ Hermano/a ☐ Mascota ☐ Sacerdote o clérigo ☐ Maestro/a ☐ Dios ☐ Peluche ☐ Otro familiar ☐ Ninguno de estos	1	2	3	4
22. Simplemente **no puede** enfrentar a la persona con quien tiene el problema o la situación.	1	2	3	4
23. Desearía que alguien viniera y lo/a sacara de este lío.	1	2	3	4

CUANDO SE ENFRENTA AL ESTRÉS DE PROBLEMAS EN SU FAMILIA:	¿Con qué frecuencia hace esto? Nunca	Casi nunca	A veces	Mucho
Ud. ya ha terminado la mitad de la encuesta. Antes de continuar, regrese al inicio de la primera página para recordar que tipo de problemas con su familia mencionó. Recuerde responder a las preguntas de abajo pensando en esas cosas.				
24. Hace algo para tratar de arreglar el problema o adopta medidas para cambiar la situación. (*recuerde marcar un número.)* → **Escriba algo que haya hecho**: _____	1	2	3	4
25. Pensamientos sobre los problemas con su familia se le entran de repente en mente.	1	2	3	4
26. Cuando tiene problemas con su familia lo siente en el cuerpo.(*recuerde marcar un número.)* → **Marque todo lo que le pasa:** ☐ Su corazón se acelera ☐ Su respiración se acelera ☐ Ninguno de estos ☐ Se siente acalorado/a y sudoroso/a ☐ Sus músculos se tensan	1	2	3	4
27. **Trata** de alejarse de las personas y cosas que lo hacen sentir disgustado/a o le recuerdan los problemas.	1	2	3	4
28. No se siente como si mismo/a cuando está enfrentando problemas con su familia, es como si estuviera alejado/a de todo.	1	2	3	4
29. Toma las cosas como son; va con la corriente.	1	2	3	4
30. Piensa en cosas alegres para alejar la mente de los problemas o de como se siente.	1	2	3	4
31. Cuando tiene problemas con su familia **no puede parar** de pensar en ellos y en como se siente.	1	2	3	4
32. Obtiene compasión, comprensión o apoyo de alguien. (*recuerde marcar un número.*) → **Marque todos a los que ha acudido:** ☐ Padre o madre ☐ Amigo/a ☐ Hermano/a ☐ Mascota ☐ Sacerdote o clérigo ☐ Maestro/a ☐ Dios ☐ Peluche ☐ Otro familia ☐ Ninguno de estos	1	2	3	4
33. Cuando tiene problemas con su familia no siempre puede controlar lo que hace. (*recuerde marcar un número.*)→ **Marque todo lo que pasa:** ☐ No puede parar de comer ☐ No puede parar de hablar ☐ Hace cosas peligrosas ☐ Tiene que arreglar o checar cosas constantemente ☐ Ninguno de estos	1	2	3	4
34. Se dice a sí mismo/a que las cosas podrían estar peor.	1	2	3	4
35. Su mente se pone en blanco cuando tiene problemas de familia, no puede pensar en nada.	1	2	3	4
36. Se dice a si mismo/a que esto no importa, que no es gran cosa.	1	2	3	4
37. Cuando tiene problemas con su familia inmediatamente se siente muy: (*recuerde marcar un número.*)→ **Marque todo lo que siente:** ☐ Enojado/a ☐ Triste ☐ Ninguno de estos ☐ Preocupado/a o ansioso/a ☐ Asustado/a	1	2	3	4
38. Es muy difícil para él/ella concentrarse o poner atención cuando tiene problemas con su familia.	1	2	3	4

— – _____

CUANDO SE ENFRENTA AL ESTRÉS DE PROBLEMAS EN SU FAMILIA:	¿Con qué frecuencia hace esto? Nunca	Casi nunca	A veces	Mucho
39. Piense en las cosas que está aprendiendo de la situación o en algo bueno que saldrá de esto.	1	2	3	4
40. Cuando tiene problemas con su familia no puede parar de pensar en lo que hizo o dijo.	1	2	3	4
41. Cuando tiene problemas con su familia se dice a si mismo/a, "Esto no es real."	1	2	3	4
42. Cuando tiene problemas de familia termina echado/a en la casa o durmiendo mucho.	1	2	3	4
43. Mantiene su mente alejada de los problemas con su familia por medio de: (*recuerde encerrar un número.*)→ **Marque todo lo que hace:** ☐ Hacer ejercicio ☐ Visitar amigos ☐ Ver televisión ☐ Jugar video juegos ☐ Realizar un pasatiempo ☐ Escuchar música ☐ Ninguno de estos	1	2	3	4
44. Cuando tiene problemas con su familia se disgusta por cosas que usualmente no le molestan.	1	2	3	4
45. Hace algo para calmarse cuando tiene problemas con su familia. **Marque todo lo que hace:** ☐ Respirar profundo ☐ Rezar ☐ Caminar ☐ Escuchar música ☐ Tomar un descanso ☐ Meditar ☐ Ninguno de estos	1	2	3	4
46. Se paraliza cuando tiene problemas con su familia; **no puede** hacer nada.	1	2	3	4
47. Cuando tiene problemas con su familia a veces actúa sin pensar.	1	2	3	4
48. Mantiene sus emociones bajo control cuando lo tiene que hacer, después las expresa cuando no van a empeorar las cosas.	1	2	3	4
49. Cuando tiene problemas con su familia no logra iniciar las cosas que tiene que hacer.	1	2	3	4
50. Se dice a si mismo/a que todo saldrá bien.	1	2	3	4
51. Cuando tiene problemas con su familia **no puede dejar** de pensar en **por qué** está pasando esto.	1	2	3	4
52. Piensa en maneras de reírse de la situación para que no parezca tan mala.	1	2	3	4
53. Sus pensamientos se aceleraran cuando tiene problemas con su familia.	1	2	3	4
54. Se imagina algo muy divertido o emocionante pasando en su vida.	1	2	3	4
55. Cuando tiene problemas con su familia se puede poner tan disgustado/a que ni puede recordar lo que pasó o lo que hizo.	1	2	3	4
56. Trata de convencerse de que esto nunca pasó.	1	2	3	4
57. Cuando tiene problemas con su familia a veces **no puede** controlar lo que hace o dice.	1	2	3	4

Appendix D

Child-Report of Socialization of Coping (SOC)-Family Stress Version (English Child-Report)

Circle which **PARENT** you talk to the most when you feel stressed about problems within your family:

Mom **Dad** **Other:_____**

This is a list of things that parents sometimes say or do when their child is dealing with stress related to family problems. For each item on the list below, circle one number (1 to 5) that shows how much the parent you circled above says or does these things when you are stressed about problems in your family. (Problems within the family may include things like people in your family arguing or fighting, not being as close to parents, siblings, or other family members as you'd like, competing with your siblings, not feeling like family members understand you, or anything else that you think causes problems or stress within your family).

	When I am stressed about problems in my family:	**Not At All**	**A Little Bit**	**Some**	**Pretty Much**	**Very Much**
1.	My parent encourages me to deal with the situation head on rather than ignoring it.	1	2	3	4	5
2.	My parent encourages me to look for something good in what is happening.	1	2	3	4	5
3.	My parent encourages me to think that everything will be all right.	1	2	3	4	5
4.	My parent encourages me to try to stop myself from thinking about the problem.	1	2	3	4	5
5.	My parent encourages me to think about happy things to take my mind off the problem.	1	2	3	4	5
6.	My parent encourages me to **NOT** focus on things that make me feel bad.	1	2	3	4	5
7.	My parent encourages me to get help from her/him or others when figuring out how to deal with my feelings.	1	2	3	4	5
8.	My parent encourages me to find something positive that came from the experience.	1	2	3	4	5

9.	My parent encourages me to keep my mind off how I'm feeling by getting involved in other fun activities.	1	2	3	4	5
10.	My parent encourages me to keep away from things that make me feel bad.	1	2	3	4	5
11.	My parent encourages me to do something to try to fix the problem or take action to change things.	1	2	3	4	5
12.	My parent encourages me to stay away from the people that make me feel upset.	1	2	3	4	5
13.	My parent encourages me to discuss my feelings with my parents or others.	1	2	3	4	5
14.	My parent encourages me to think about ways to deal with the problem.	1	2	3	4	5
15.	My parent encourages me to try **NOT** to think about things that make me upset.	1	2	3	4	5
16.	My parent encourages me to keep away from things related to the problem.	1	2	3	4	5
17.	My parent encourages me to think of ways to laugh about it so it won't seem so bad.	1	2	3	4	5
18.	My parent encourages me to think about things I'm learning from the situation.	1	2	3	4	5
19.	My parent encourages me to stay away from the family members that remind me of the problem.	1	2	3	4	5
20.	My parent encourages me to keep busy so that I don't focus on the problem.	1	2	3	4	5
21.	My parent encourages me to let someone know how I feel.	1	2	3	4	5
22.	My parent encourages me to keep from thinking about my negative feelings.	1	2	3	4	5
23.	My parent encourages me to do something to calm myself down.	1	2	3	4	5

24.	My parent encourages me to **NOT** focus on the problem.	1	2	3	4	5

Appendix E

Child-Report of Socialization of Coping (SOC)-Family Stress Version (Spanish Parent-Report)

CUANDO MI HIJO/A SE ESTRESA POR PROBLEMAS FAMILIARES:

Esta es una lista de cosas que dicen o hacen a veces los padres cuando sus hijos enfrentan el estrés relacionado con problemas familiares. Para cada punto de la siguiente lista, marque con un círculo un número (del 1 al 5) que demuestre cuánto dice o hace estas cosas cuando su hijo/a está estresado por problemas familiares. (Los problemas dentro de la familia podrían incluir cosas como que los miembros de la familia discutan o peleen, no ser tan cercano a los padres, hermanos u otros familiares como le gustaría ser, competir con los hermanos, sentir que los miembros de la familia no lo entienden, o cualquier otra cosa que le cause problemas o estrés a su hijo/a en su familia).

Cuando mi hijo/a está estresado/a por problemas familiares, LO/A ANIMO A…		Para nada	Un poco	En cierta medida	Mucho	Muchísimo
1.	Afrontar la situación en lugar de ignorarla.	1	2	3	4	5
2.	Buscar algo bueno en lo que sucede.	1	2	3	4	5
3.	Pensar que todo estará bien.	1	2	3	4	5
4.	Intentar que deje de pensar en el problema.	1	2	3	4	5
5.	Pensar en cosas agradables para sacar el problema de su mente.	1	2	3	4	5
6.	**NO** concentrarse en las cosas que lo/a hacen sentir mal.	1	2	3	4	5
7.	Obtener ayuda de mi parte o de otros cuando intenta descifrar cómo afrontar sus sentimientos.	1	2	3	4	5
8.	Encontrar algo positivo que haya surgido de la experiencia.	1	2	3	4	5
9.	Mantener su mente despejada de lo que siente participando en otras actividades.	1	2	3	4	5
10.	Mantenerse alejado/a de las cosas que lo/a hacen sentir mal.	1	2	3	4	5
11.	Hacer algo para intentar solucionar el problema o tomar medidas para cambiar las cosas.	1	2	3	4	5
12.	Mantenerse alejado/a de miembros de la familia que lo/a hacen sentir mal.	1	2	3	4	5

13.	Hablar sobre sus sentimientos conmigo o con otras personas.	1	2	3	4	5
14.	Pensar en formas de tratar con el problema.	1	2	3	4	5
15.	Intentar **NO** pensar sobre las cosas que lo/a hacen sentir mal.	1	2	3	4	5
16.	Mantenerse alejado/a de las cosas relacionadas con el problema.	1	2	3	4	5
17.	Pensar en formas de reírse sobre el problema de forma que no parezca tan malo.	1	2	3	4	5
18.	Pensar en las cosas que está aprendiendo de la situación.	1	2	3	4	5
19.	Mantenerse alejado/a de miembros de la familia que le hacen recordar el problema.	1	2	3	4	5
20.	Mantenerse tan ocupado/a que no deba concentrarse en el problema.	1	2	3	4	5
21.	Decirle a alguien cómo se siente.	1	2	3	4	5
22.	Evitar que piense en sus sentimientos negativos.	1	2	3	4	5
23.	Hacer algo para calmarse.	1	2	3	4	5
24.	**NO** concentrarse en el problema.	1	2	3	4	5

Appendix F

Children's Report of Parenting Behavior Inventory (CRPBI) (English Child-Report)

Circle which parent is doing this assessment with you today: **Mom Dad Other: _____**

I would like you to think about the past three months. I am going to ask you some questions about your experiences with the parent you indicated above. Please tell me how often each of these statements was true during the past three months.

	Almost never or never	**Once in a while**	**Sometimes**	**A lot of the time (frequently)**	**Almost always or always**
1. My parent made me feel better after talking over my worries with him/her.	1	2	3	4	5
2. My parent saw my good points more than my faults.	1	2	3	4	5
3. My parent spoke to me in a warm and friendly voice.	1	2	3	4	5
4. My parent understood my problems and worries.	1	2	3	4	5
5. My parent was able to make me feel better when I was upset.	1	2	3	4	5
6. My parent cheered me up when I was sad.	1	2	3	4	5
7. My parent had a good time with me.	1	2	3	4	5
8. My parent told or showed me that he/she liked me just the way I am.	1	2	3	4	5
9. My parent got angry when I was noisy around the house.	1	2	3	4	5

10. My parent got so mad at me that he/she called me names.	1	2	3	4	5
11. My parent screamed at me when I did something wrong.	1	2	3	4	5
12. My parent lost his/her temper with me when I didn't help around the house.	1	2	3	4	5
13. My parent bothered me until I did what he/she wanted me to do.	1	2	3	4	5
14. When I did something wrong, my parent said he/she was disgusted with me.	1	2	3	4	5
15. When I did something wrong, my parent punished me in front of my friends.	1	2	3	4	5

Appendix G

Children's Report of Parenting Behavior Inventory (CRPBI) (Spanish Parent-Report)

Me gustaría que pensaras en su vida durante los últimos tres meses. Le voy a hacer algunas preguntas acerca de sus experiencias con su hijo/a. Por favor dime que tan seguido cada una de estas frases fue cierta durante los últimos tres meses.

	Casi nunca o nunca	De vez en cuando	A veces	Muchas veces (frecuente-mente)	Casi siempre o siempre
1. Yo hice sentir mejor a mi hijo/a después de platicar con él/ella sobre mis preocupaciones.	1	2	3	4	5
2. Yo me fijé más en los puntos buenos de mi hijo/a, que en sus fallas.	1	2	3	4	5
3. Yo hablé con mi hijo/a con una voz amigable y templada.	1	2	3	4	5
4. Yo comprendí los problemas y preocupaciones de mi hijo/a.	1	2	3	4	5
5. Yo fui capaz de hacer sentir mejor a mi hijo/a cuando él/ella se sentía mal.	1	2	3	4	5
6. Animé a mi hijo/a cuando él/ella estaba triste.	1	2	3	4	5
7. Yo tuve un buen tiempo con mi hijo/a.	1	2	3	4	5
8. Yo le dije o le mostré a mi hijo/a que lo/a quería tal como es.	1	2	3	4	5
9. Yo me enojé con mi hijo/a cuando él/ella fue ruidoso/a en la casa.	1	2	3	4	5

10. Me enojé tanto con mi hijo/a que lo/la llamé por apodos.	1	2	3	4	5
11. Le grité a mi hijo/a cuando él/ella hizo algo mal.	1	2	3	4	5
12. Yo perdí el temperamento con mi hijo/a cuando no me ayudó en casa.	1	2	3	4	5
13. Fastidié a mi hijo/a hasta que hizo lo que yo quería que hiciera.	1	2	3	4	5
14. Cuando mi hijo/a hizo algo mal, yo le dije que estaba disgustada con él/ella.	1	2	3	4	5
15. Cuando mi hijo/a hizo algo mal, lo/la castigué en frente de sus amigos.	1	2	3	4	5

Appendix H

Standardized / Unstandardized Direct Effects (With Standard Errors) and Corresponding p-Values for Each Parent Model Using Anxious/Depressed

Predictor variable	*Outcome variable*							
Model 1	Primary Control Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.70 (.08) / .89 (.12)	<.001 / <.001	-.16 (.18) / -.01 (.01)	*ns*	.07 (.15) / .28 (.56)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.36 (.13) / .02 (.01)	.007 / .006	-.18 (.14) / -.55 (.43)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	.06 (.10) / 3.62 (5.84)	*ns*	—	—
Child Gender	.01 (.08) / .02 (.12)	*ns*	.01 (.10) / .00 (.01)	*ns*	.04 (.10) / .16 (.46)	*ns*	—	—
Parent Depressive Symptoms	.08 (.07) / .01 (.01)	*ns*	-.12 (.10) / .00 (.00)	*ns*	.20 (.12) / .07 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.018 / .035
Baseline Anxious/Depressed	.00 (.11) / .00 (.03)	*ns*	-.02 (.10) / .00 (.00)	*ns*	.39 (.11) / .28 (.09)	<.001 / .002	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.06 (.10) / .07 (.11)	*ns*	-.23 (.11) / -.01 (.01)	.029 / .043	.08 (.11) / .28 (.37)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .012
Model 2	Secondary Control Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.60 (.10) / .76 (.15)	<.001 / <.001	.14 (.13) / .01 (.01)	*ns*	.07 (.13) / .28 (.48)	*ns*	—	—
Secondary Control Coping Suggestions	—	—	.15 (.12) / .01 (.01)	*ns*	-.17 (.11) / -.51 (.37)	*ns*	—	—
Secondary Control Youth Coping	—	—	—	—	-.10 (.09) / -5.74 (5.45)	*ns*	—	—

Child Gender	.00 (.09) / .00 (.14)	*ns*	.03 (.11) / .00 (.01)	*ns*	.04 (.10) / .17 (.46)	*ns*	—	—
Parent Depressive Symptoms	.08 (.10) / .01 (.01)	*ns*	.02 (.13) / .00 (.00)	*ns*	.19 (.12) / .06 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.018 / .035
Baseline Anxious/Depressed	-.10 (.11) / -.02 (.03)	*ns*	-.16 (.11) / .00 (.00)	*ns*	.35 (.11) / .25 (.09)	.001 / .005	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.14 (.11) / .15 (.13)	*ns*	-.23 (.12) / -.01 (.01)	.044 / .048	.07 (.11) / .22 (.38)	*ns*	-.29 (.11) / -0.25 (.10)	.010 / .012

Model 3	Disengagement Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.45 (.13) / .59 (.17)	<.001 / <.001	-.22 (.13) / -.01 (.01)	*ns*	.02 (.12) / .07 (.45)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.03 (.12) / .00 (.00)	*ns*	-.15 (.11) / -.44 (.31)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.00 (.11) / .22 (11.37)	*ns*	—	—
Child Gender	.01 (.12) / .01 (.18)	*ns*	-.08 (.10) / .00 (.00)	*ns*	.03 (.10) / .15 (.46)	*ns*	—	—
Parent Depressive Symptoms	.11 (.09) / .01 (.01)	*ns*	.03 (.11) / .00 (.00)	*ns*	.20 (.12) / .07 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.019 / .036
Baseline Anxious/Depressed	-.12 (.12) / -.03 (.03)	*ns*	.07 (.12) / .00 (.00)	*ns*	.36 (.11) / .26 (.09)	.001 / .003	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.21 (.12) / .24 (.15)	*ns*	.05 (.11) / .00 (.00)	*ns*	.09 (.11) / .31 (.38)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .011

Model 4	Primary Control Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.70 (.08) / .89 (.12)	<.001 / <.001	.19 (.15) / .01 (.01)	*ns*	.08 (.15) / .32 (.56)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.06 (.14) / .00 (.01)	*ns*	-.16 (.13) / -.47 (.41)	*ns*	—	—

Secondary Control Youth Coping	—	—	—	—	-.16 (.13) / -6.55 (5.62)	*ns*	—	—
Child Gender	.01 (.08) / .02 (.12)	*ns*	.03 (.11) / .00 (.01)	*ns*	.04 (.10) / .18 (.46)	*ns*	—	—
Parent Depressive Symptoms	.08 (.07) / .01 (.01)	*ns*	.03 (.13) / .00 (.00)	*ns*	.19 (.12) / .06 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.018 / .035
Baseline Anxious/Depressed	.00 (.11) / .00 (.03)	*ns*	-.18 (.11) / .00 (.00)	*ns*	.37 (.11) / .27 (.09)	.001 / .004	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.06 (.10) / .07 (.11)	*ns*	-.22 (.11) / -.01 (.01)	*ns*	.05 (.11) / .16 (.38)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .012

Model 5	Primary Control Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.70 (.08) / .89 (.12)	<.001 / <.001	-.15 (.16) / -.01 (.01)	*ns*	.06 (.15) / .24 (.57)	*ns*	—	—
Primary Control Coping Suggestions	—	—	-.08 (.16) / .00 (.00)	*ns*	-.16 (.13) / -.48 (.42)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.00 (.10) / -.41 (11.35)	*ns*	—	—
Child Gender	.01 (.08) / .02 (.12)	*ns*	-.08 (.10) / .00 (.00)	*ns*	.04 (.10) / .17 (.46)	*ns*	—	—
Parent Depressive Symptoms	.08 (.07) / .01 (.01)	*ns*	.04 (.11) / .00 (.00)	*ns*	.19 (.12) / .06 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.018 / .036
Baseline Anxious/Depressed	.00 (.11) / .00 (.03)	*ns*	.06 (.12) / .00 (.00)	*ns*	.39 (.11) / .28 (.09)	<.001 / .002	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.06 (.10) / .07 (.11)	*ns*	.06 (.10) / .00 (.00)	*ns*	.07 (.11) / .23 (.37)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .011

Model 6	Secondary Control Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.60 (.10) / .76 (.15)	<.001 / <.001	-.05 (.18) / .00 (.01)	*ns*	.06 (.12) / .24 (.46)	*ns*	—	—

Secondary Control Coping Suggestions	——	——	.23 (.16) / .01 (.01)	*ns*	-.20 (.12) / -.58 (.38)	*ns*	——	——
Primary Control Youth Coping	——	——	——	——	.05 (.09) / 3.10 (5.56)	*ns*	——	——
Child Gender	.00 (.09) / .00 (.14)	*ns*	.02 (.11) / .00 (.01)	*ns*	.03 (.10) / .15 (.46)	*ns*	——	——
Parent Depressive Symptoms	.08 (.10) / .01 (.01)	*ns*	-.11 (.10) / .00 (.00)	*ns*	.20 (.12) / .07 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.018 / .035
Baseline Anxious/Depressed	-.02 (.03)	*ns*	.01 (.10) / .00 (.00)	*ns*	.37 (.11) / .27 (.09)	<.001 / .002	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	-.10 (.11) / .15 (.13)	*ns*	-.24 (.11) / -.01 (.01)	.034 / .047	.10 (.11) / .32 (.37)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .012

Model 7	Secondary Control Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.60 (.10) / .76 (.15)	<.001 / <.001	-.20 (.14) / -.01 (.01)	*ns*	.06 (.13) / .23 (.50)	*ns*	——	——
Secondary Control Coping Suggestions	——	——	-.01 (.13) / .00 (.00)	*ns*	-.19 (.12) / -.55 (.37)	*ns*	——	——
Disengagement Youth Coping	——	——	——	——	.00 (.11) / .45 (11.44)	*ns*	——	——
Child Gender	.00 (.09) / .00 (.14)	*ns*	-.08 (.10) / .00 (.00)	*ns*	.04 (.10) / .16 (.46)	*ns*	——	——
Parent Depressive Symptoms	.08 (.10) / .01 (.01)	*ns*	.04 (.11) / .00 (.00)	*ns*	.19 (.12) / .06 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.019 / .036
Baseline Anxious/Depressed	-.10 (.11) / -.02 (.03)	*ns*	.06 (.12) / .00 (.00)	*ns*	.37 (.11) / .27 (.09)	.001 / .003	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.14 (.11) / .15 (.13)	*ns*	.06 (.10) / .00 (.00)	*ns*	.09 (.11) / .29 (.37)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .011

Model 8	Disengagement Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*

Parental Acceptance	.45 (.13) / .59 (.17)	<.001 / <.001	.01 (.17) / .00 (.01)	*ns*	.02 (.11) / .07 (.41)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.19 (.15) / .01 (.01)	*ns*	-.16 (.11) / -.46 (.32)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	.05 (.09) / 2.74 (5.67)	*ns*	—	—
Child Gender	.01 (.12) / .01 (.18)	*ns*	.02 (.11) / .00 (.01)	*ns*	.03 (.10) / .14 (.47)	*ns*	—	—
Parent Depressive Symptoms	.11 (.09) / .01 (.01)	*ns*	-.11 (.10) / .00 (.00)	*ns*	.20 (.12) / .07 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.018 / .035
Baseline Anxious/Depressed	-.12 (.12) / -.03 (.03)	*ns*	.01 (.10) / .00 (.00)	*ns*	.36 (.11) / .26 (.09)	.001 / .003	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.21 (.12) / .24 (.15)	*ns*	-.25 (.11) / -.01 (.01)	.028 / .042	.10 (.12) / .34 (.38)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .012

Model 9	Disengagement Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.45 (.13) / .59 (.17)	<.001 / <.001	.20 (.12) / .01 (.01)	*ns*	.04 (.12) / .14 (.44)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.08 (.11) / .00 (.01)	*ns*	-.15 (.11) / -.41 (.31)	*ns*	—	—
Secondary Control Youth Coping	—	—	—	—	-.11 (.09) / -6.29 (5.50)	*ns*	—	—
Child Gender	.01 (.12) / .01 (.18)	*ns*	.03 (.11) / .00 (.01)	*ns*	.04 (.10) / .16 (.46)	*ns*	—	—
Parent Depressive Symptoms	.11 (.09) / .01 (.01)	*ns*	.03 (.13) / .00 (.00)	*ns*	.20 (.11) / .07 (.04)	*ns*	-.24 (.10) / -.02 (.01)	.018/ .035
Baseline Anxious/Depressed	-.12 (.12) / -.03 (.03)	*ns*	-.17 (.11) / .00 (.00)	*ns*	.34 (.11) / .25 (.09)	.002 / .006	-.08 (.10) / -.02 (.02)	*ns*
Harsh Parenting	.21 (.12) / .24 (.15)	*ns*	-.23 (.12) / -.01 (.01)	*ns*	.07 (.12) / .23 (.39)	*ns*	-.29 (.11) / -.25 (.10)	.010 / .012

Appendix I

Standardized / Unstandardized Direct Effects (With Standard Errors) and Corresponding p-Values for Each Parent Model Using Withdrawn/Depressed

Predictor variable	*Outcome variable*							
Model 1	Primary Control Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.70 (.07) / .88 (.11)	<.001 / <.001	-.15 (.17) / -.01 (.01)	*ns*	.01 (.14) / .02 (.46)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.34 (.14) / .02 (.01)	.015 / .012	-.33 (.13) / -.89 (.39)	.011 / .023	—	—
Primary Control Youth Coping	—	—	—	—	-.16 (.08) / -8.80 (4.42)	.047 / .047	—	—
Child Gender	.03 (.08) / .05 (.12)	*ns*	.03 (.10) / .00 (.01)	*ns*	.05 (.09) / .22 (.38)	*ns*	—	—
Parent Depressive Symptoms	.13 (.07) / .01 (.01)	*ns*	-.08 (.11) / .00 (.00)	*ns*	-.07 (.08) / -.02 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .036
Baseline Withdrawn/Depressed	-.15 (.10) / -.05 (0.03)	*ns*	-.12 (.11) / .00 (.00)	*ns*	.44 (.11) / .39 (.10)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.08 (.10) / .09 (.11)	*ns*	-.22 (.11) / -.01 (.01)	*ns*	.01 (.10) / .03 (.31)	*ns*	-.30 (.11) / -.26 (.10)	.005 / .006
Model 2	Secondary Control Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.60 (.09) / .76 (.14)	<.001 / <.001	.14 (.14) / .01 (.01)	*ns*	-.06 (.13) / -.19 (.44)	*ns*	—	—
Secondary Control Coping Suggestions	—	—	.18 (.11) / .01 (.01)	*ns*	-.24 (.11) / -.64 (.32)	.034 / .047	—	—
Secondary Control Youth Coping	—	—	—	—	-.13 (.10) / -7.15 (5.30)	*ns*	—	—

Child Gender	.00 (.09) / .01 (.14)	*ns*	.00 (.10) / .00 (.01)	*ns*	.04 (.10) / .17 (.40)	*ns*	—	—
Parent Depressive Symptoms	.10 (.10) / .01 (.01)	*ns*	-.05 (.15) / .00 (.00)	*ns*	-.08 (.09) / -.03 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .036
Baseline Withdrawn/Depressed	-.17 (.10) / -.06 (.03)	*ns*	.07 (.11) / .00 (.00)	*ns*	.49 (.11) / .42 (.11)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.14 (.11) / .16 (.13)	*ns*	-.27 (.11) / -.02 (.01)	.016 / .018	.01 (.11) / .04 (.31)	*ns*	-.30 (.11) / -.26 (.10)	.005 / .006
Model 3	Disengagement Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.45 (.12) / .60 (.17)	<.001 / <.001	-.22 (.13) / -.01 (.01)	*ns*	-.12 (.11) / -.40 (.40)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.03 (.12) / .00 (.00)	*ns*	-.20 (.10) / -.51 (.27)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.13 (.09) / 12.53 (8.38)	*ns*	—	—
Child Gender	.00 (.12) / .00 (.19)	*ns*	-.07 (.10) / .00 (.00)	*ns*	.05 (.10) / .19 (.42)	*ns*	—	—
Parent Depressive Symptoms	.12 (.09) / .01 (.01)	*ns*	.04 (.11) / .00 (.00)	*ns*	-.08 (.09) / -.03 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .035
Baseline Withdrawn/Depressed	-.13 (.10) / -.05 (.03)	*ns*	.05 (.12) / .00 (.00)	*ns*	.48 (.12) / .41 (.11)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.20 (.12) / .23 (.14)	*ns*	.06 (.10) / .00 (.00)	*ns*	.05 (.11) / .14 (.33)	*ns*	-.30 (.11) / -.26 (.09)	.004 / .006
Model 4	Primary Control Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.70 (.07) / .88 (.11)	<.001 / <.001	.20 (.15) / .01 (.01)	*ns*	.06 (.14) / .22 (.48)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.07 (.14) / .00 (.01)	*ns*	-.37 (.13) / -1.02 (.40)	.003 / .010	—	—

Secondary Control Youth Coping	—	—	—	—	-.15 (.10) / -8.10 (5.45)	*ns*	—	—
Child Gender	.03 (.08) / .05 (.12)	*ns*	-.01 (.11) / .00 (.01)	*ns*	.05 (.09) / .21 (.37)	*ns*	—	—
Parent Depressive Symptoms	.13 (.07) / .01 (.01)	*ns*	-.04 (.15) / .00 (.00)	*ns*	-.06 (.08) / -.02 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .036
Baseline Withdrawn/Depressed	-.15 (.10) / -.05 (.03)	*ns*	.05 (.12) / .00 (.00)	*ns*	.48 (.10) / .42 (.10)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.08 (.10) / .09 (.11)	*ns*	-.25 (.11) / -.01 (.01)	.022 / .025	.01 (.11) / .02 (.32)	*ns*	-.30 (.11) / -.26 (.10)	.005 / .006

Model 5	Primary Control Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.70 (.07) / .88 (.11)	<.001 / <.001	-.16 (.17) / -.01 (.01)	*ns*	.05 (.14) / .19 (.48)	*ns*	—	—
Primary Control Coping Suggestions	—	—	-.07 (.16) / .00 (.00)	*ns*	-.38 (.13) / -1.03 (.40)	.003 / .009	—	—
Disengagement Youth Coping	—	—	—	—	.12 (.08) / 11.72 (8.22)	*ns*	—	—
Child Gender	.03 (.08) / .05 (.12)	*ns*	-.07 (.10) / .00 (.00)	*ns*	.06 (.09) / .25 (.38)	*ns*	—	—
Parent Depressive Symptoms	.13 (.07) / .01 (.01)	*ns*	.05 (.11) / .00 (.00)	*ns*	-.06 (.08) / -.02 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.014 / .034
Baseline Withdrawn/Depressed	-.15 (.10) / -.05 (.03)	*ns*	.03 (.12) / .00 (.00)	*ns*	.47 (.11) / .41 (.11)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.08 (.10) / .09 (.11)	*ns*	.07 (.10) / .00 (.00)	*ns*	.04 (.10) / .11 (.31)	*ns*	-.30 (.11) / -.26 (.09)	.005 / .006

Model 6	Secondary Control Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.60 (.09) / .76 (.14)	<.001 / <.001	-.04 (.18) / .00 (.01)	*ns*	-.09 (.12) / -.29 (.42)	*ns*	—	—

Secondary Control Coping Suggestions	—	—	.20 (.16) / .01 (.01)	*ns*	-.22 (.12) / -.60 (.34)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	-.20 (.08) / -10.82 (4.47)	.015 / .015	—	—
Child Gender	.00 (.09) / .01 (.14)	*ns*	.03 (.11) / .00 (.01)	*ns*	.05 (.10) / .19 (.40)	*ns*	—	—
Parent Depressive Symptoms	.10 (.10) / .01 (.01)	*ns*	-.05 (.11) / .00 (.00)	*ns*	-.09 (.09) / -.03 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .036
Baseline Withdrawn/Depressed	-.17 (.10) / -.06 (.03)	*ns*	-.14 (.11) / .00 (.00)	*ns*	.44 (.11) / .38 (.11)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.14 (.11) / .16 (.13)	*ns*	-.22 (.11) / .01 (.01)	*ns*	.01 (.10) / .03 (.31)	*ns*	-.30 (.11) / -.26 (.10)	.005 / .006

Model 7	Secondary Control Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.60 (.09) / .76 (.14)	<.001 / <.001	-.20 (.14) / -.01 (.01)	*ns*	-.05 (.13) / -.16 (.45)	*ns*	—	—
Secondary Control Coping Suggestions	—	—	-.01 (.13) / .00 (.00)	*ns*	-.26 (.12) / -.72 (.34)	.024 / .038	—	—
Disengagement Youth Coping	—	—	—	—	.13 (.09) / 12.91 (8.55)	*ns*	—	—
Child Gender	.00 (.09) / .01 (.13)	*ns*	-.07 (.10) / -.03 (.00)	*ns*	.05 (.10) / .21 (.40)	*ns*	—	—
Parent Depressive Symptoms	.10 (.10) / .01 (.01)	*ns*	.04 (.11) / .00 (.00)	*ns*	-.08 (.09) / -.03 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .035
Baseline Withdrawn/Depressed	-.17 (.10) / -.06 (.03)	*ns*	.04 (.12) / .00 (.00)	*ns*	.47 (.11) / .11 (.41)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.14 (.11) / .16 (.13)	*ns*	.07 (.10) / .00 (.00)	*ns*	.13 (.31)	*ns*	-.30 (.11) / -.26 (.09)	.004 / .006

Model 8	Disengagement Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*

Parental Acceptance	.45 (.00) / .60 (.17)	<.001 / <.001	.01 (.16) / .00 (.01)	*ns*	-.14 (.11) / -.48 (.37)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.17 (.15) / .01 (.01)	*ns*	-.17 (.10) / -.43 (.27)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	-.21 (.08) / -11.35 (4.45)	.010 / .011	—	—
Child Gender	.00 (.12) / .00 (.19)	*ns*	.04 (.11) / .00 (.01)	*ns*	.04 (.10) / .17 (.41)	*ns*	—	—
Parent Depressive Symptoms	.12 (.09) / .01 (.01)	*ns*	-.05 (.11) / .00 (.00)	*ns*	-.09 (.09) / -.03 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .036
Baseline Withdrawn/Depressed	-.13 (.10) / -.05 (.03)	*ns*	-.15 (.11) / .00 (.00)	*ns*	.44 (.11) / .38 (.11)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.20 (.11) / .23 (.14)	*ns*	-.23 (.11) / -.01 (.01)	*ns*	.01 (.11) / -.26 (.10)	*ns*	-.30 (.11) / -.26 (.10)	.005 / .006

Model 9	Disengagement Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.45 (.12) / .60 (.27)	<.001 / <.001	.20 (.12) / .01 (.01)	*ns*	-.12 (.12) / -.39 (.40)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.10 (.10) / .01 (.01)	*ns*	-.18 (.10) / -.47 (.26)	*ns*	—	—
Secondary Control Youth Coping	—	—	—	—	-.15 (.10) / -7.79 (5.39)	*ns*	—	—
Child Gender	.00 (.12) / .00 (.19)	*ns*	.00 (.11) / .00 (.01)	*ns*	.04 (.10) / .15 (.41)	*ns*	—	—
Parent Depressive Symptoms	.12 (.09) / .01 (.01)	*ns*	-.05 (.15) / .00 (.00)	*ns*	-.09 (.09) / -.03 (.03)	*ns*	-.25 (.10) / -.02 (.01)	.015 / .036
Baseline Withdrawn/Depressed	-.13 (.10) / -.05 (.03)	*ns*	.05 (.11) / .00 (.00)	*ns*	.49 (.11) / .42 (.11)	<.001 / <.001	-.04 (.10) / -.01 (.03)	*ns*
Harsh Parenting	.20 (.11) / .23 (.14)	*ns*	-.27 (.11) / -.02 (.01)	.019 / .022	.02 (.11) / .04 (.33)	*ns*	-.30 (.11) / -.26 (.10)	.005 / .006

Appendix J

Standardized / Unstandardized Direct Effects (With Standard Errors) and Corresponding p-Values for Each Child Model Using Anxious/Depressed

Predictor variable	*Outcome variable*							
Model 1	Primary Control Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.67 (.08) / .70 (.09)	<.001 / <.001	.22 (.14) / .01 (.01)	*ns*	-.17 (.12) / -.92 (.63)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.12 (.14) / .01 (.01)	*ns*	.12 (.14) / .62 (.69)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	-.17 (.10) / -21.43 (12.22)	*ns*	—	—
Child Gender	.06 (.08) / .10 (.14)	*ns*	.27 (.10) / .02 (.01)	.004 / .009	.15 (.10) / 1.23 (.82)	*ns*	—	—
Parent Depressive Symptoms	-.11 (.09) / -.01 (.01)	*ns*	-.17 (.10) / .00 (.00)	*ns*	.03 (.08) / .02 (.05)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.03 (.08) / .01 (.02)	*ns*	-.21 (.10) / .00 (.00)	.046 / .041	.54 (.10) / .64 (.17)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.18 (.08) / .22 (.10)	.021 / .024	-.08 (.103) / .00 (.01)	*ns*	.01 (.08) / .04 (.53)	*ns*	-.19 (.13) / -.23 (.14)	*ns*
Model 2	Secondary Control Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.65 (.08) / .65 (.09)	<.001 / <.001	.25 (.13) / .01 (.01)	.045 / .038	-.09 (.11) / -.45 (.60)	*ns*	—	—
Secondary Control Coping Suggestions	—	—	.09 (.12) / .01 (.01)	*ns*	-.03 (.12) / -.16 (.62)	*ns*	—	—
Secondary Control Youth Coping	—	—	—	—	-.13 (.09) / -13.01 (8.72)	*ns*	—	—

Child Gender	-.02 (.09) / -.04 (.14)	*ns*	.02 (.12) / .00 (.01)	*ns*	.10 (.09) / .84 (.76)	*ns*	—	—
Parent Depressive Symptoms	-.08 (.10) / -.01 (.01)	*ns*	-.08 (.11) / .00 (.00)	*ns*	.04 (.08) / .02 (.06)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.00 (.01) / .00 (.02)	*ns*	-.21 (.11) / .00 (.00)	*ns*	.55 (.10) / .64 (.18)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.17 (.09) / .21 (.10)	.041 / .047	-.04 (.11) / .00 (.01)	*ns*	.05 (.08) / .28 (.51)	*ns*	-.19 (.13) / -.23 (.14)	*ns*
Model 3	Disengagement Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.52 (.09) / .49 (.09)	<.001 / <.001	-.37 (.10) / -.01 (.00)	<.001 / <.001	-.06 (.11) / -.30 (.59)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.00 (.11) / .00 (.00)	*ns*	-.12 (.13) / -.68 (.67)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.08 (.10) / 15.09 (19.55)	*ns*	—	—
Child Gender	.03 (.10) / .04 (.14)	*ns*	-.26 (.10) / -.01 (.00)	.011 / .014	.12 (.09) / 1.01 (.76)	*ns*	—	—
Parent Depressive Symptoms	-.04 (.11) / .00 (.01)	*ns*	.27 (.09) / .00 (.00)	.002 / .003	.03 (.09) / .02 (.06)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.04 (.10) / .01 (.02)	*ns*	.23 (.09) / .00 (.00)	.013 / .018	.57 (.10) / .69 (.19)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.23 (.10) / .25 (.12)	.027 / .026	.04 (.11) / .00 (.00)	*ns*	.07 (.08) / .44 (.51)	*ns*	-.19 (.13) / -.23 (.14)	*ns*
Model 4	Primary Control Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.67 (.08) / .70 (.09)	<.001 / <.001	.31 (.12) / .02 (.01)	.009 / .006	-.17 (.13) / -.90 (.70)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.00 (.12) / .00 (.01)	*ns*	.10 (.14) / .51 (.70)	*ns*	—	—

Secondary Control Youth Coping	—	—	—	—	-.14 (.09) / -13.20 (8.39)	*ns*	—	—
Child Gender	.06 (.08) / .10 (.14)	*ns*	.02 (.12) / .00 (.01)	*ns*	.10 (.09) / .82 (.75)	*ns*	—	—
Parent Depressive Symptoms	-.11 (.09) / -.01 (.01)	*ns*	-.08 (.11) / .00 (.00)	*ns*	.05 (.08) / .03 (.06)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.03 (.08) / .01 (.02)	*ns*	-.22 (.11) / .00 (.00)	*ns*	.54 (.10) / .64 (.17)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.18 (.08) / .22 (.10)	.021 / .024	-.02 (.11) / .00 (.01)	*ns*	.02 (.09) / .12 (.54)	*ns*	-.19 (.13) / -.23 (.14)	*ns*
Model 5	Primary Control Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.67 (.07) / .70 (.09)	<.001 / <.001	-.22 (.11) / -.01 (.00)	.046 /.049	-.19 (.13) / -1.01 (.68)	*ns*	—	—
Primary Control Coping Suggestions	—	—	-.22 (.12) / -.01 (.00)		.12 (.14) / .59 (.70)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.09 (.09) / 18.26 (17.62)	*ns*	—	—
Child Gender	.06 (.08) / .10 (.14)	*ns*	-.25 (.10) / -.01 (.00)	.015 / .018	.12 (.09) / 1.01 (.74)	*ns*	—	—
Parent Depressive Symptoms	-.11 (.09) / -.01 (.01)	*ns*	.25 (.08) / .00 (.00)	.003 / .004	.04 (.09) / .03 (.06)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.03 (.08) / .01 (.02)	*ns*	.24 (.09) / .00 (.00)	.010 / .014	.56 (.10) / .66 (.17)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.18 (.08) / .22 (.10)	.021 / .024	.07 (.11) / .00 (.00)	*ns*	.02 (.09) / .10 (.54)	*ns*	-.19 (.13) / -.23 (.14)	*ns*
Model 6	Secondary Control Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.65 (.08) / .65 (.09)	<.001 / <.001	.36 (.13) / .02 (.01)	.007 / .005	-.07 (.11) / -.35 (.58)	*ns*	—	—

Secondary Control Coping Suggestions	—	—	-.09 (.14) / .00 (.01)	*ns*	-.05 (.12) / -.25 (.63)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	-.16 (.09) / -20.23 (11.54)	*ns*	—	—
Child Gender	-.02 (.09) / -.04 (.14)	*ns*	.28 (.09) / .02 (.01)	.003 / .009	.15 (.10) / 1.23 (.83)	*ns*	—	—
Parent Depressive Symptoms	-.08 (.10) / -.01 (.01)	*ns*	-.19 (.11) / .00 (.00)	*ns*	.02 (.08) / .01 (.05)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.00 (.10) / .00 (.02)	*ns*	-.21 (.11) / .00 (.00)	*ns*	.55 (.10) / .65 (.18)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.17 (.09) / .21 (.11)	.041 / .047	-.04 (.11) / .00 (.01)	*ns*	.04 (.08) / .25 (.50)	*ns*	-.19 (.13) / -.23 (.14)	*ns*
Model 7	Secondary Control Coping Suggestions	*p*	Disengagement Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.65 (.08) / .65 (.09)	<.001 / <.001	-.26 (.11) / -.01 (.00)	.014 / .018	-.10 (.12) / -.55 (.61)	*ns*	—	—
Secondary Control Coping Suggestions	—	—	-.16 (.11) / .00 (.00)	*ns*	-.03 (.13) / -.13 (.65)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.07 (.11) / 14.15 (20.66)	*ns*	—	—
Child Gender	-.02 (.09) / -.04 (.14)	*ns*	-.26 (.10) / -.01 (.00)	.010 / .012	.12 (.09) / .99 (.77)	*ns*	—	—
Parent Depressive Symptoms	-.08 (.10) / -.01 (.01)	*ns*	.26 (.09) / .00 (.00)	.004 / .005	.03 (.09) / .02 (.06)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.00 (.09) / .00 (.02)	*ns*	.23 (.10) / .00 (.00)	.016 / .024	.57 (.10) / .67 (.18)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.17 (.09) / .21 (.10)	.040 / .045	.06 (.11) / .00 (.00)	*ns*	.04 (.08) / .28 (.50)	*ns*	-.19 (.13) / -.23 (.14)	*ns*
Model 8	Disengagement Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*

Parental Acceptance	.52 (.09) / .49 (.09)	<.001 / <.001	.30 (.11) / .01 (.01)	.008 / .007	-.03 (.10) / -.18 (.52)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.00 (.13) / .00 (.01)	*ns*	-.12 (.12) / -.67 (.64)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	-.16 (.09) / -19.96 (11.30)	*ns*	—	—
Child Gender	.03 (.10) / .04 (.14)	*ns*	.28 (.10) / .02 (.01)	.003 / .008	.15 (.09) / 1.24 (.82)	*ns*	—	—
Parent Depressive Symptoms	-.04 (.11) / -.00 (.01)	*ns*	-.18 (.11) / .00 (.00)	*ns*	.02 (.08) / .01 (.05)	*ns*	.06 (.11) / .01 (.01)	*ns*
Baseline Anxious/Depressed	.04 (.10) / .01 (.02)	*ns*	-.21 (.11) / .00 (.00)	*ns* / .048	.56 (.10) / .67 (.18)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.23 (.10) / .25 (.11)	.026 / .026	-.06 (.10) / .00 (.01)	*ns*	.06 (.08) / .39 (.50)	*ns*	-.19 (.13) / -.23 (.14)	*ns*

Model 9	Disengagement Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Anxious/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.52 (.09) / .49 (.09)	<.001 / <.001	.30 (.11) / .02 (.01)	.009 / .005	.05 (.11) / -.25 (.56)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.03 (.09) / .00 (.01)	*ns*	-.11 (.13) / -.63 (.65)	*ns*	—	—
Secondary Control Youth Coping	—	—	—	—	-.13 (.09) / -12.60 (8.81)	*ns*	—	—
Child Gender	.03 (.10) / .04 (.14)	*ns*	.02 (.12) / .00 (.01)	*ns*	.10 (.09) / .85 (.75)	*ns*	—	—
Parent Depressive Symptoms	-.04 (.11) / .00 (.01)	*ns*	-.08 (.10) / .00 (.00)	*ns*	.04 (.08) / .02 (.06)	*ns*	.06 (.11) / .01 (.02)	*ns*
Baseline Anxious/Depressed	.04 (.10) / .01 (.02)	*ns*	-.22 (.12) / .00 (.00)	*ns*	.56 (.10) / .66 (.18)	<.001 / <.001	.04 (.09) / .01 (.02)	*ns*
Harsh Parenting	.23 (.10) / .25 (.11)	.026 / .026	-.03 (.11) / .00 (.01)	*ns*	.07 (.08) / .43 (.51)	*ns*	-.19 (.13) / -.23 (.14)	*ns*

Appendix K

Standardized / Unstandardized Direct Effects (With Standard Errors) and Corresponding p-Values for Each Child Model Using Withdrawn/Depressed

Predictor variable	*Outcome variable*							
Model 1	Primary Control Coping Suggestions	*p*	Primary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.69 (.08) / .72 (.09)	<.001 / <.001	.16 (.14) / .01 (.01)	*ns*	-.25 (.14) / -.78 (.44)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.13 (.14) / .01 (.01)	*ns*	.13 (.12) / .38 (.38)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	-.06 (.10) / -.78 (.44)	*ns*	—	—
Child Gender	.05 (.08) / .09 (.13)	*ns*	.26 (.10) / .02 (.01)	.007 / .015	.08 (.11) / -4.45 (7.62)	*ns*	—	—
Parent Depressive Symptoms	-.11 (.09) / -.01 (.01)	*ns*	-.16 (.10) / .00 (.00)	*ns*	.00 (.10) / .00 (.04)	*ns*	.07 (.10) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.05 (.09) / .02 (.03)	*ns*	-.18 (.11) / .00 (.00)	*ns*	.43 (.11) / .48 (.13)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .004
Harsh Parenting	.19 (.08) / .24 (.10)	.015 / .018	-.12 (.10) / -.01 (.01)	*ns*	-.01 (.10) / -.04 (.39)	*ns*	-.23 (.12) / -.27 (.14)	.065 / .044
Model 2	Secondary Control Coping Suggestions	*p*	Secondary Control Youth Coping	*p*	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.65 (.09) / .65 (.09)	<.001 / <.001	.21 (.13) / .01 (.01)	*ns*	-.12 (.15) / -.37 (.47)	*ns*	—	—
Secondary Control Coping Suggestions	—	—	.10 (.12) / .01 (.01)	*ns*	-.05 (.12) / -.14 (.36)	*ns*	—	—
Secondary Control Youth Coping	—	—	—	—	-.10 (.09) / -5.83 (5.50)	*ns*	—	—

Child Gender	-.03 (.09) / -.05 (.15)	*ns*	.00 (.12) / .00 (.01)	*ns*	.06 (.11) / .31 (.54)	*ns*	—	—
Parent Depressive Symptoms	-.08 (.10) / -.01 (.01)	*ns*	-.06 (.11) / .00 (.00)	*ns*	-.01 (.11) / -.00 (.04)	*ns*	.07 (.10) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.02 (.10) / .01 (.04)	*ns*	-.13 (.14) / .00 (.00)	*ns*	.44 (.10) / .49 (.13)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .004
Harsh Parenting	.18 (.08) / .21 (.10)	.027 / .032	-.06 (.11) / .00 (.01)	*ns*	.03 (.10) / .10 (.39)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .044

Model 3	Disengagement Coping Suggestions		Disengagement Youth Coping		Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.53 (.09) / .50 (.09)	<.001 / <.001	-.27 (.12) / -.01 (.00)	.018 / .019	-.14 (.15) / -.42 (.46)	*ns*	—	—
Disengagement Coping Suggestions	—	—	-.01 (.11) / .00 (.00)	*ns*	-.06 (.12) / -.20 (.40)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.02 (.14) / 2.74 (15.87)	*ns*	—	—
Child Gender	.03 (.09) / .04 (.14)	*ns*	-.27 (.10) / -.01 (.00)	.006 / .009	.08 (.11) / .38 (.56)	*ns*	—	—
Parent Depressive Symptoms	-.04 (.11) / -.01 (.01)	*ns*	.25 (.09) / .00 (.00)	.004 / .004	-.01 (.11) / -.00 (.04)	*ns*	.07 (.11) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.04 (.11) / .02 (.04)	*ns*	.29 (.09) / .00 (.00)	.002 / .004	.45 (.11) / .50 (.14)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .005
Harsh Parenting	.24 (.10) / .26 (.11)	.020 / .021	.09 (.11) / .00 (.00)	*ns*	.04 (.11) / .14 (.40)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .044

Model 4	Primary Control Coping Suggestions		Secondary Control Youth Coping		Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.69 (.08) / .72 (.09)	<.001 / <.001	.27 (.12) / .01 (.01)	.030 / .026	-.23 (.14) / -.72 (.46)	*ns*	—	—
Primary Control Coping Suggestions	—	—	.00 (.11) / .00 (.01)	*ns*	.12 (.12) / .36 (.37)	*ns*	—	—

Secondary Control Youth Coping	—	—	—	—	-.10 (.09) / -5.93 (5.39)	*ns*	—	—
Child Gender	.05 (.08) / .09 (.13)	*ns*	-.01 (.12) / .00 (.01)	*ns*	.06 (.11) / .30 (.53)	*ns*	—	—
Parent Depressive Symptoms	-.11 (.09) / -.01 (.01)	*ns*	-.07 (.11) / .00 (.00)	*ns*	.00 (.11) / .00 (.04)	*ns*	.07 (.10) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.05 (.09) / .02 (.03)	*ns*	-.13 (.13) / .00 (.00)	*ns*	.43 (.10) / .48 (.12)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .004
Harsh Parenting	.19 (.08) / .24 (.10)	.015 / .017	-.05 (.11) / .00 (.01)	*ns*	-.01 (.10) / -.02 (.39)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .044
Model 5	Primary Control Coping Suggestions		Disengagement Youth Coping		Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.69 (.08) / .72 (.09)	<.001 / <.001	-.12 (.12) / -.00 (.00)	*ns*	-.25 (.15) / -.79 (.46)	*ns*	—	—
Primary Control Coping Suggestions	—	—	-.23 (.11) / -.01 (.00)	.037 / .050	.13 (.12) / .39 (.38)	*ns*	—	—
Disengagement Youth Coping	—	—	—	—	.04 (.14) / 5.04 (15.90)	*ns*	—	—
Child Gender	.05 (.08) / .09 (.13)	*ns*	-.25 (.10) / -.01 (.00)	.008 / .011	.08 (.11) / .38 (.55)	*ns*	—	—
Parent Depressive Symptoms	-.11 (.09) / -.01 (.01)	*ns*	.23 (.08) / .00 (.00)	.006 / .007	.00 (.11) / .00 (.04)	*ns*	.07 (.11) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.05 (.08) / .02 (.03)	*ns*	.30 (.09) / .00 (.00)	.001 / .003	.43 (.11) / .48 (.13)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .004
Harsh Parenting	.19 (.08) / .24 (.10)	.014 / .016	.13 (.11) / .00 (.00)	*ns*	-.01 (.11) / -.03 (.41)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .045
Model 6	Secondary Control Coping Suggestions		Primary Control Youth Coping		Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.65 (.09) / .65 (.09)	<.001 / <.001	.30 (.14) / .01 (.01)	.034 / .031	-.13 (.15) / -.40 (.45)	*ns*	—	—

Secondary Control Coping Suggestions	——	——	-.08 (.14) / .00 (.01)	*ns*	-.05 (.12) / -.17 (.37)	*ns*	——	——
Primary Control Youth Coping	——	——	——	——	-.05 (.10) / -3.69 (7.10)	*ns*	——	——
Child Gender	-.03 (.09) / -.05 (.15)	*ns*	.26 (.10) / .02 (.01)	.006 / .015	.08 (.11) / .40 (.57)	*ns*	——	——
Parent Depressive Symptoms	-.08 (.10) / -.01 (.01)	*ns*	-.18 (.10) / .00 (.00)	*ns*	-.01 (.11) / -.01 (.04)	*ns*	.07 (.10) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.02 (.10) / .01 (.04)	*ns*	-.18 (.11) / .00 (.00)	*ns*	.44 (.11) / .49 (.13)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .004
Harsh Parenting	.18 (.08) / .21 (.10)	.027 / .032	-.08 (.10) / .00 (.01)	*ns*	.03 (.11) / .11 (.40)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .044

Model 7	Secondary Control Coping Suggestions		Disengagement Youth Coping		Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.65 (.09) / .65 (.09)	<.001 / <.001	-.17 (.12) / .00 (.00)	*ns*	-.14 (.15) / -.44 (.48)	*ns*	——	——
Secondary Control Coping Suggestions	——	——	-.17 (.11) / -.01 (.00)	*ns*	-.05 (.12) / -.15 (.38)	*ns*	——	——
Disengagement Youth Coping	——	——	——	——	.02 (.14) / 1.83 (16.23)	*ns*	——	——
Child Gender	-.03 (.09) / -.05 (.14)	*ns*	-.27 (.10) / -.01 (.00)	.005 / .007	.07 (.12) / .35 (.58)	*ns*	——	——
Parent Depressive Symptoms	-.08 (.10) / -.01 (.01)	*ns*	.24 (.09) / .00 (.00)	.007 / .008	-.01 (.11) / .00 (.04)	*ns*	.07 (.11) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.02 (.10) / .01 (.04)	*ns*	.29 (.10) / .00 (.00)	.003 / .006	.45 (.11) / .50 (.14)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .005
Harsh Parenting	.18 (.08) / .21 (.10)	.027 / .033	.12 (.11) / .00 (.00)	*ns*	.03 (.11) / .12 (.41)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .043

Model 8	Disengagement Coping Suggestions	Primary Control Youth Coping	Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*

Parental Acceptance	.53 (.09) / .50 (.09)	<.001 / <.001	.25 (.12) / .01 (.01)	.046 / .047	-13 (.13) / -.41 (.42)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.00 (.13) / .00 (.01)	*ns*	-.06 (.12) / -.20 (.39)	*ns*	—	—
Primary Control Youth Coping	—	—	—	—	-.05 (.09) / -3.56 (7.06)	*ns*	—	—
Child Gender	.03 (.10) / .04 (.14)	*ns*	.27 (.10) / .02 (.01)	.006 / .014	.08 (.11) / .42 (.56)	*ns*	—	—
Parent Depressive Symptoms	-.04 (.11) / -.01 (.01)	*ns*	-.17 (.11) / .00 (.00)	*ns*	-.01 (.11) / .00 (.04)	*ns*	.07 (.10) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.04 (.12) / .02 (.04)	*ns*	-.18 (.11) / .00 (.00)	*ns*	.45 (.11) / .50 (.13)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .004
Harsh Parenting	.24 (.10) / .26 (.11)	.020 / .021	-.10 (.10) / -.01 (.01)	*ns*	.03 (.11) / .13 (.39)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .044

Model 9	Disengagement Coping Suggestions		Secondary Control Youth Coping		Outcome Withdrawn/ Depressed	*p*	Parental Acceptance	*p*
Parental Acceptance	.53 (.09) / .50 (.09)	<.001 / <.001	.26 (.12) / .01 (.01)	.037 / .030	-.18 (.14) / -.37 (.44)	*ns*	—	—
Disengagement Coping Suggestions	—	—	.02 (.10) / .00 (.01)	*ns*	-.06 (.12) / -.19 (.39)	*ns*	—	—
Secondary Control Youth Coping	—	—	—	—	-.10 (.09) / -5.85 (5.50)	*ns*	—	—
Child Gender	.03 (.10) / .04 (.14)	*ns*	-.01 (.12) / .00 (.01)	*ns*	.07 (.11) / .33 (.53)	*ns*	—	—
Parent Depressive Symptoms	-.04 (.11) / -.01 (.01)	*ns*	-.07 (.11) / .00 (.00)	*ns*	-.01 (.11) / .00 (.04)	*ns*	.07 (.10) / .01 (.01)	*ns*
Baseline Withdrawn/Depressed	.04 (.12) / .02 (.04)	*ns*	-.13 (.14) / .00 (.00)	*ns*	.44 (.10) / .49 (.12)	<.001 / <.001	-.28 (.09) / -.10 (.04)	.003 / .004
Harsh Parenting	.24 (.10) / .26 (.11)	.020 / .021	-.05 (.11) / .00 (.01)	*ns*	.03 (.10) / .13 (.38)	*ns*	-.23 (.12) / -.27 (.14)	*ns* / .044

Appendix L

Unstandardized Indirect Effects with Corresponding 95% Bias-Corrected Bootstrapped Confidence Intervals, Standard Errors, and Standardized Indirect Effects for Each Parent Model Using Anxious/Depressed

Path	*Unstandardized Indirect Effect*	*Unstandardized 95% BC-B CI*	*Unstandardized S.E.*	*Standardized Indirect Effect*
Model 1				
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping	.016*	.004, .028	.006	.256
Parental Acceptance → Primary Control Youth Coping → Outcome Anxious/Depressed	-.037	-.384, .063	.091	-.010
Parental Acceptance → Primary Control Coping Suggestions → Outcome Anxious/Depressed	-.485	-1.200, .278	.370	-.128
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping → Outcome Anxious/Depressed	.057	-.110, .304	.100	.015
Model 2				
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping	.006	-.003, .016	.005	.089
Parental Acceptance → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.051	-.333, .051	.084	-.014
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Anxious/Depressed	-.389	-.975, .132	.272	-.103
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.032	-.239, .017	.055	-.009
Model 3				
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping	.000	-.003, .005	.002	.012

Parental Acceptance → Disengagement Youth Coping → Outcome Anxious/Depressed	-.002	-.211, .212	.104	.000
Parental Acceptance → Disengagement Coping Suggestions → Outcome Anxious/Depressed	-.256	-.773, .066	.204	-.068
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping → Outcome Anxious/Depressed	.000	-.047, .057	.024	.000
Model 4				
Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping	.003	-.011, .014	.006	.041
Parental Acceptance → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.078	-.433, .049	.113	-.021
Parental Acceptance → Primary Control Coping Suggestions → Outcome Anxious/Depressed	-.411	-1.097, .286	.344	-.109
Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.017	-.179, .056	.056	-.004
Model 5				
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping	-.002	-.009, .006	.004	-.056
Parental Acceptance → Disengagement Youth Coping → Outcome Anxious/Depressed	.002	-.189, .198	.094	.001
Parental Acceptance → Primary Control Coping Suggestions → Outcome Anxious/Depressed	-.428	-1.115, .282	.353	-.113
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping → Outcome Anxious/Depressed	.001	-.091, .106	.049	.000
Model 6				
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping	.008	-.003, .020	.006	.138

Parental Acceptance → Primary Control Youth Coping → Outcome Anxious/Depressed	-.009	-.245, .080	.074	-.002
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Anxious/Depressed	-.444	-1.046, .105	.283	-.118
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping → Outcome Anxious/Depressed	.026	-.045, .189	.055	.007
Model 7				
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping	.000	-.006, .006	.003	-.004
Parental Acceptance → Disengagement Youth Coping → Outcome Anxious/Depressed	-.003	-.217, .218	.104	-.001
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Anxious/Depressed	-.419	-1.006, .123	.277	-.111
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping → Outcome Anxious/Depressed	.000	-.068, .071	.033	.000
Model 8				
Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping	.005	-.003, .015	.004	.084
Parental Acceptance → Primary Control Youth Coping → Outcome Anxious/Depressed	.001	-.113, .168	.066	.000
Parental Acceptance → Disengagement Coping Suggestions → Outcome Anxious/Depressed	-.269	-.775, .071	.208	-.072
Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping → Outcome Anxious/Depressed	.014	-.031, .141	.039	.004
Model 9				
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping	.002	-.004, .011	.003	.034

Parental Acceptance → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.078	-.371, .040	.092	-.021
Parental Acceptance → Disengagement Coping Suggestions → Outcome Anxious/Depressed	-.244	-.741, .088	.201	-.065
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.013	-.167, .015	.035	-.004

Note. BC-B CI = Bias-Corrected Bootstrapped Confidence Interval; S.E. = Standard Error.
* $p < .05$.

Appendix M

Unstandardized Indirect Effects with Corresponding 95% Bias-Corrected Bootstrapped Confidence Intervals, Standard Errors, and Standardized Indirect Effects for Each Parent Model Using Withdrawn/Depressed

Path	*Unstandardized Indirect Effect*	*Unstandardized 95% BC-B CI*	*Unstandardized S.E.*	*Standardized Indirect Effect*
Model 1				
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping	.014*	.002, .026	.006	.234
Parental Acceptance → Primary Control Youth Coping → Outcome Withdrawn/Depressed	.081	-.066, .428	.118	.024
Parental Acceptance → Primary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.782*	-1.493, -.248	.324	-.229
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.127*	-.389, -.011	.088	-.037
Model 2				
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping	.007	-.002, .018	.005	.108
Parental Acceptance → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.063	-.346, .057	.093	-.019
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.490*	-1.123, -.100	.252	-.144
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.049	-.270, .014	.064	-.014
Model 3				
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping	.000	-.003, .005	.002	.011
Parental Acceptance → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.095	-.332, .053	.092	-.028
Parental Acceptance → Disengagement Coping Suggestions → Outcome Withdrawn/Depressed	-.304*	-.763, -.033	.179	-.090
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping → Outcome Withdrawn/Depressed	.005	-.050, .102	.035	.001
Model 4				

Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping	.003	-.011, .013	.006	.048
Parental Acceptance → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.103	-.490, .043	.129	-.030
Parental Acceptance → Primary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.891*	-1.602, -.387	.321	-.259
Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.025	-.208, .071	.065	-.007
Model 5				
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping	-.002	-.008, .007	.004	-.050
Parental Acceptance → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.064	-.328, .100	.105	-.019
Parental Acceptance → Primary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.904*	-1.627, -.381	.326	-.262
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.021	-.187, .094	.068	-.006
Model 6				
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping	.007	-.005, .018	.006	.121
Parental Acceptance → Primary Control Youth Coping → Outcome Withdrawn/Depressed	.024	-.221, .330	.131	.007
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.457*	-1.109, -.038	.270	-.135
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.080	-.308, .027	.078	-.024
Model 7				
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping	.000	-.005, .006	.003	-.003
Parental Acceptance → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.092	-.352, .070	.103	-.027
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.545*	-1.229, -.145	.273	-.159
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.001	-.106, .105	.051	.000
Model 8				

Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping	.005	-.003, .014	.004	.076
Parental Acceptance → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.006	-.256, .238	.118	-.002
Parental Acceptance → Disengagement Coping Suggestions → Outcome Withdrawn/Depressed	-.254	-.694, .018	.178	-.076
Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.053	-.218, .017	.054	-.016
Model 9				
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping	.003	-.003, .011	.003	.046
Parental Acceptance → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.100	-.374, .031	.098	-.030
Parental Acceptance → Disengagement Coping Suggestions → Outcome Withdrawn/Depressed	-.277*	-.715, -.009	.171	-.082
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.023	-.194, .016	.042	-.007

Note. BC-B CI = Bias-Corrected Bootstrapped Confidence Interval; S.E. = Standard Error.
* $p < .05$.

Appendix N

Unstandardized Indirect Effects with Corresponding 95% Bias-Corrected Bootstrapped Confidence Intervals, Standard Errors, and Standardized Indirect Effects for Each Child Model Using Anxious/Depressed

Path	*Unstandardized Indirect Effect*	*Unstandardized 95% BC-B CI*	*Unstandardized S.E.*	*Standardized Indirect Effect*
Model 1				
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping	.003	.004, .013	.004	.082
Parental Acceptance → Primary Control Youth Coping → Outcome Anxious/Depressed	-.203	-.768, .018	.175	-.038
Parental Acceptance → Primary Control Coping Suggestions → Outcome Anxious/Depressed	.435	-.474, 1.479	.495	.082
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping → Outcome Anxious/Depressed	-.074	-.450, .053	.119	-.014
Model 2				
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping	.003	-.005, .012	.004	.058
Parental Acceptance → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.178	-.620, .038	.162	-.034
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Anxious/Depressed	-.102	-.833, .821	.410	-.019
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.041	-.237, .041	.065	-.008
Model 3				
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping	.000	-.003, .003	.002	-.002
Parental Acceptance → Disengagement Youth Coping → Outcome Anxious/Depressed	-.149	-.415, .465	.209	-.028
Parental Acceptance → Disengagement Coping Suggestions → Outcome Anxious/Depressed	-.330	-.950, .410	.339	-.062
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping → Outcome Anxious/Depressed	-.001	-.093, .095	.046	.000
Model 4				

Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping	.000	-.009, .008	.004	.001
Parental Acceptance → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.222	-.683, .027	.173	-.042
Parental Acceptance → Primary Control Coping Suggestions → Outcome Anxious/Depressed	.358	-.555, 1.418	.502	.068
Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.001	-.133, .156	.068	.000
Model 5				
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping	-.004	-.008, .000	.002	-.146
Parental Acceptance → Disengagement Youth Coping → Outcome Anxious/Depressed	-.109	-.364, .183	.141	-.021
Parental Acceptance → Primary Control Coping Suggestions → Outcome Anxious/Depressed	.417	-.536, 1.459	.507	.079
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping → Outcome Anxious/Depressed	-.072	-.237, .159	.094	-.014
Model 6				
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping	-.002	-.010, .005	.004	-.057
Parental Acceptance → Primary Control Youth Coping → Outcome Anxious/Depressed	-.311*	-.878, -.025	.206	-.058
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Anxious/Depressed	-.159	-.918, .723	.414	-.030
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping → Outcome Anxious/Depressed	.049	-.088, .287	.091	.009
Model 7				
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping	-.003	-.007, .001	.002	-.105
Parental Acceptance → Disengagement Youth Coping → Outcome Anxious/Depressed	-.100	-.356, .306	.168	-.019
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Anxious/Depressed	-.087	-.907, .800	.430	-.016
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping → Outcome Anxious/Depressed	-.040	-.169, .175	.079	-.008
Model 8				

Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping	.000	-.005, .006	.003	.303
Parental Acceptance → Primary Control Youth Coping → Outcome Anxious/Depressed	-.257*	-.786, -.016	.181	-.048
Parental Acceptance → Disengagement Coping Suggestions → Outcome Anxious/Depressed	-.326	-.929, .359	.321	-.061
Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping → Outcome Anxious/Depressed	-.001	-.162, .116	.065	.000
Model 9				
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping	.001	-.005, .006	.003	.014
Parental Acceptance → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.203	-.650, .048	.166	-.038
Parental Acceptance → Disengagement Coping Suggestions → Outcome Anxious/Depressed	-.308	-.925, .394	.326	-.058
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping → Outcome Anxious/Depressed	-.010	-.127, .051	.040	-.002

Note. BC-B CI = Bias-Corrected Bootstrapped Confidence Interval; S.E. = Standard Error.
* $p < .05$.

Appendix O

Unstandardized Indirect Effects with Corresponding 95% Bias-Corrected Bootstrapped Confidence Intervals, Standard Errors, and Standardized Indirect Effects for Each Child Model Using Withdrawn/Depressed

Path	*Unstandardized Indirect Effect*	*Unstandardized 95% BC-B CI*	*Unstandardized S.E.*	*Standardized Indirect Effect*
Model 1				
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping	.004	-.004, .013	.004	.086
Parental Acceptance → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.030	-.299, .057	.077	-.010
Parental Acceptance → Primary Control Coping Suggestions → Outcome Withdrawn/Depressed	.276	-.239, .848	.276	.088
Parental Acceptance → Primary Control Coping Suggestions → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.016	-.183, .035	.048	-.005
Model 2				
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping	.003	-.005, .012	.004	.062
Parental Acceptance → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.065	-.327, .041	.084	-.021
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.093	-.600, .380	.248	-.030
Parental Acceptance → Secondary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.020	-.151, .023	.037	-.006
Model 3				
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping	.000	-.003, .003	.002	-.005
Parental Acceptance → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.020	-.227, .264	.126	-.006
Parental Acceptance → Disengagement Coping Suggestions → Outcome Withdrawn/Depressed	-.101	-.512, .314	.203	-.032
Parental Acceptance → Disengagement Coping Suggestions → Disengagement Youth Coping → Outcome Withdrawn/Depressed	.000	-.056, .058	.026	.000
Model 4				

Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping	.000	-.009, .008	.004	.001
Parental Acceptance → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.086	-.345, .052	.094	-.027
Parental Acceptance → Primary Control Coping Suggestions → Outcome Withdrawn/Depressed	.258	-.219, .838	.268	.082
Parental Acceptance → Primary Control Coping Suggestions → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	.000	-.070, .073	.033	.000
Model 5				
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping	-.004	-.009, .000	.002	-.157
Parental Acceptance → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.016	-.178, .128	.074	-.005
Parental Acceptance → Primary Control Coping Suggestions → Outcome Withdrawn/Depressed	.277	-.227, .864	.273	.088
Parental Acceptance → Primary Control Coping Suggestions → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.021	-.145, .159	.079	-.007
Model 6				
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping	-.002	-.010, .006	.004	-.054
Parental Acceptance → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.047	-.319, .123	.105	-.015
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.111	-.641, .356	.250	-.035
Parental Acceptance → Secondary Control Coping Suggestions → Primary Control Youth Coping → Outcome Withdrawn/Depressed	.008	-.027, .140	.035	.003
Model 7				
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping	-.003	-.007, .001	.002	-.113
Parental Acceptance → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.008	-.173, .174	.092	-.003
Parental Acceptance → Secondary Control Coping Suggestions → Outcome Withdrawn/Depressed	-.100	-.623, .419	.256	-.032
Parental Acceptance → Secondary Control Coping Suggestions → Disengagement Youth Coping → Outcome Withdrawn/Depressed	-.006	-.121, .115	.062	-.002
Model 8				

Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping	.000	-.005, .006	.003	.002
Parental Acceptance → Primary Control Youth Coping → Outcome Withdrawn/Depressed	-.037	-.278, .090	.087	-.012
Parental Acceptance → Disengagement Coping Suggestions → Outcome Withdrawn/Depressed	-.101	-.503, .296	.199	-.032
Parental Acceptance → Disengagement Coping Suggestions → Primary Control Youth Coping → Outcome Withdrawn/Depressed	.000	-.049, .049	.023	.000
Model 9				
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping	.001	-.005, .006	.003	.013
Parental Acceptance → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.081	-.344, .048	.092	-.026
Parental Acceptance → Disengagement Coping Suggestions → Outcome Withdrawn/Depressed	-.095	-.483, .308	.197	-.030
Parental Acceptance → Disengagement Coping Suggestions → Secondary Control Youth Coping → Outcome Withdrawn/Depressed	-.004	-.078, .025	.022	-.001

Note. BC-B CI = Bias-Corrected Bootstrapped Confidence Interval; S.E. = Standard Error.
** $p < .05$.*

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